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ABSTRACT

This book presents an organized picture of how professional counselors and counseling psychologists can become primary prevention agents and shows that this approach is rooted in the very origins of counseling and counseling psychology. Section I presents the origins and a conceptual understanding of primary prevention in mental health. It shows how primary prevention counseling emerges from an integration of counseling with primary prevention. Section II contains the heart of the discussion about primary preventive counseling itself. An organized framework of this type of counseling and descriptions of direct and indirect methods of intervention in primary preventive counseling are presented. Section III discusses two important and challenging matters facing the effective practice of this type of counseling: planning and evaluation. Section IV suggests appropriate graduate education and training necessary for the proper preparation of future primary preventive counselors. Each chapter includes: a summary; a list of issues for reflection and discussion; an annotated bibliography of highly recommended supplementary readings; and a list of references and suggested readings. (ABL)

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PRIMARY PREVENTIVE COUNSELING

EMPOWERING PEOPLE AND SYSTEMS

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To

Suzanne and Zachary

PREFACE

The forces of remediation and prevention have struggled like titans throughout the compatible histories of professional counseling and counseling psychology. Is the main goal of counseling to correct deep psychological dysfunction? Or is it to facilitate growth and development? Does psychotherapy rule? Or are short-term counseling and prevention the dominant ways these professionals should help others? Perhaps all of these goals and methods are important and justifiable. However, having offered that, doesn't a kind of "pecking order" exist?

I believe the latter is the case. Remediation and prevention are both consistently endorsed by official statements of the counseling establishment. If anything, maybe prevention has historically been emphasized on paper. For instance, read these words that are drawn from the American Psychological Association brochure, "What Is A Counseling Psychologist?" (Education and Training Committee of the Division of Counseling Psychology, 1983), which describe how counseling psychologists work:

> ...These interventions tend to emphasize preventive treatment, health maintenance, short-term or time-limited problem solving, goal-focused counseling, and vocational counseling. Preventive and educative strategies are frequent in the intervention repertoire...Regardless of the setting or evaluation methods, the unique aspects of counseling psychology, in both assessment and treatment, are its identification of impediments to development, appraisal of potential, and focus upon growth. (p. 2)

Similar statements can be found to describe "professional counselors." This label is used to describe fifth or sixth year graduate level counselors, many of whom are associated with the American Association for Counseling and Development. Yet, in terms of day-to-day practice—for example, how training programs are organized, what third-party payments provide coverage for, the contents of psychologist and counselor-with-endorsement licensing regulations, and how many professionals and doctoral students alike tend to describe themselves to others—clearly reflect a far different reality.

In the real world, remediation, therapy, and long-term counseling hold the upper hand. Thus, the conflict arises between statements about the preeminence of prevention and growth and development, contrasted

with the higher practical identification and energies that are given to remediation and long-term therapy.

But, once again, a stirring is afoot in the counseling professions and in society at large. It runs counter to the prevailing tide of remediation.

This gathering movement rides on the swell of primary prevention and goes by various synonyms, including wellness and health promotion. One can scarcely ever pick up the local newspaper or listen to the evening news without being confronted by presentations about the benefits of exercise, the importance of proper nutrition, the deadly hazards of smoking and excessive drinking, ways to manage and reduce stress in our lives, or how important support systems are for good health. People by the legion are learning to take better care of themselves so they can avoid becoming treatable patients.

On the professional front, considerable attention is being accorded primary prevention. Special issues of journals, some new books, courses being introduced into training curricula, and increased primary preventive practice are appearing. As one example, consider these words about prevention that are drawn from *Counseling Psychology: A Historic Perspective* (Whiteley, *The Counseling Psychologist, 12,* 1984):

> A fifth immediate challenge is to regain involvement in the area of prevention. Initiative has shifted to clinical and community psychology for advancing the theoretical and research base for this fundamental role of counseling psychology...The centrality of prevention to the core role of counseling psychology mandates a fundamental reawakening of interest and activity. (p. 89)

This book, *Primary Preventive Counseling: Empowering People and Systems,* is a part of this recent activity. In it, I attempt to present an organized picture of how professional counselors and counseling psychologists can become primary prevention agents, and I show how this new approach is rooted in the very origins of counseling and counseling psychology.

In *Section I* of the book, "Foundations of Primary Preventive Counseling," are presented origins and a conceptual understanding of primary prevention in mental health. I seek to show how primary preventive counseling emerges from an integration of counseling with primary prevention.

Whiteley, J. (1984). Counseling psychology: A historic perspective. *The Counseling Psychologist, 12,* 3-109.

In Chapter 1, "Primary Prevention in Mental Health," the basis for primary preventive counseling is developed. In Chapter 2, "A History of Ambivalence," is documented the push-pull involvement of the counseling professions with primary prevention. In Chapter 3, "Supportive Concepts and Approaches," are identified counseling activities that are hospitable with, or which actually embrace, primary prevention goals.

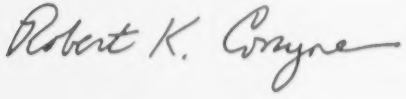
Section II of the book, "Methods Utilized" contains the heart of the discussion about primary preventive counseling itself. In Chapter 4, "A Conceptual Model," is presented an organized *framework* of this type of *counseling*. Chapters 5 and 6 contain descriptions of *direct* methods of intervention in primary preventive counseling. Chapter 5, "Education: A Direct Method," focuses on educational methods such as ecological counseling and expert witness. Chapter 6, "Organizing: A Direct Method," focuses on organizing interventions such as organization development and the use of helping groups. Chapters 7 and 8 describe the *indirect* methods of intervention that can be used. Chapter 7, "Consultation: An Indirect Method," focuses on various forms of this important intervention such as mediation and case consultation. Chapter 8, "Use of Media: An Indirect Method," presents a number of media forms, such as print and simulation gaming, that can be used creatively to reach primary prevention goals.

Section III, "Application Issues," discusses two important and challenging matters facing the effective practice of this type of counseling. Chapter 9, "Planning and Evaluation," emphasizes that sound planning and evaluation methods are integral to primary preventive counseling interventions. Contained in *Section IV,* "Education and Training Needs," is Chapter 10, "Education and Training." It suggests appropriate graduate education and training necessary for the proper preparation of future primary preventive counselors.

You are strongly encouraged to attend closely to the endings of each chapter. In the section, "Some Issues for Reflection and Discussion," are presented a number of issues that should be helpful for review or for class discussion, thus creating the opportunity for enhanced mastery and understanding. As well, in addition to a list of chapter references, where I indicate those recommended the highest for further study, I select and briefly annotate those sources which I believe to be most critical of all. By doing so, you should more easily be able to follow-up for additional study and research.

Who are all of you for whom this book is intended? I envision you as graduate students in professional counseling and counseling psychology, as well as practitioners in the field. In my judgment, this book can be used as a stand-alone text for any course that is preventive in focus, and it should be used as a supplement to existing texts in a number of basic counseling classes. Although the book speaks directly to professional counselors and counseling psychologists, I believe those in other helping fields, such as social work and community psychology, will find it of considerable interest. In addition, many of you will be counseling practitioners—employed in schools, mental health centers, social service agencies, and corporations—who are intrigued by primary prevention approaches. Other readers will be the consultants and trainers who sometimes deliver services of various kinds in these settings.

In the preparation of this book, I am grateful to many. My former colleagues at Illinois State University were a constant source of inspiration as we together designed a variety of primary preventive programs during very exciting times. My current colleagues at the University of Cincinnati have contribued to this effort as we all have "slugged it out" in the retention trenches of the 1980s, still seeking to try new things. I am especially appreciative of ISU, and to Rick Price and Hal Korn of the University of Michigan for my sabbatical of 1979-80, where I began work on this book. And for the graciousness of the University of Cincinnati, and particularly that of Linda Weiner for making this current sabbatical year possible so I can complete what I started! Joe Hollis and Accelerated Development deserve a special mention for daring to publish such a book. And, perhaps above all else, I must recognize the consideration and support given me by my family: My life partner, wife, and colleague, Lynn Rapin, and our two children, Suzanne and Zachary. I will be forever in your debt.



Robert K. Conyne

Cincinnati, Ohio
January 9, 1987

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SECTION I

FOUNDATIONS OF PRIMARY PREVENTIVE COUNSELING

INTRODUCTION TO SECTION I

Primary preventive counseling is a new form of counseling that draws upon the deepest origins of professional counseling and counseling psychology. These origins are the preventive and social reform movements with which Frank Parsons, the so-called "Father of Guidance," was associated. As well, it is shaped strongly by the primary prevention in mental health movement that is currently underway in community psychology and elsewhere. Primary preventive counseling, therefore, represents an integration of counseling's roots with the contemporary forces of prevention that are operant in mental health.

In this first section, I seek to introduce you to these foundations in order to provide a base from which we can proceed in subsequent sections of this book. The material contained in Section I is extensive, for which I feel somewhat apologetic. I remember what is like to have long reading assignments without much time to complete them! On the other hand, I believe all of what is presented is important for you to better understand the contributing forces to primary preventive counseling. So bear with it, in fact, enjoy it, as you read this material.

Section I is divided into three chapters. Chapter 1 is titled, "Primary Prevention in Mental Health." Boiling down information about this critical approach into one chapter is a challenge, and can be viewed as but a partial coverage. Yet, despite this restriction, I hope you will see that primary prevention in mental health includes two main strategies, system change and person change, each of which is attempted before the appearance of disturbance in a targeted group of people. Chapter 1 amplifies this basic orientation to helping presently well people stay well.

In Chapter 2, "A History of Ambivalence," the focus is on professional counseling, counseling psychology, and the place that primary prevention has occupied within them. Through a brief tracing of some benchmark historical events in the field, and through the results of several recent surveys of counseling and counseling psychology practitioners, you will see that the relationship between primary prevention and the counseling fields has been a checkered one. The predominant theme that emerges from this examination is one of ambivalence, where the supportive verbiage about the importance of preventive activities is only inconsistently matched by action. Yet a bright future for primary prevention and the counseling fields is possible, given a different display

of resources and commitments. In fact, some experts maintain that this very thing must happen if professional counseling and counseling psychology are to thrive, if not survive.

In Chapter 3, "Supportive Concepts and Approaches," have been included concepts and activities currently present in the counseling fields that are supportive of primary prevention. One need not look too far and hard to locate these supports. Four of the major ones are highlighted: (1) ecological, or person and environment contributions, which introduce the concept of environmental improvement to benefit people; (2) outreach and community counseling approaches, which argue for getting involved with a range of community-level interventions; (3) psychoeducational skill development approaches, which are used to build competencies in persons through a variety of means; and (4) health counseling, which intends to help people gain greater self-control over their health and destiny. Many counseling practitioners are using these approaches now in their work, and each of them supports the place of primary prevention in counseling.

As with all the chapters in this book, I encourage you to read and study the end of the chapters. Contained there is material helpful in aiding your comprehension and application of the contents. Please attend especially to "Some Issues for Reflection and Discussion," as they focus on key aspects; also, if you pursue the "Highly Recommended Supplementary Readings" which are listed, you will greatly enrich your depth of understanding.

And now to Chapter 1, "Primary Prevention in Mental Health."

CHAPTER 1

PRIMARY PREVENTION IN MENTAL HEALTH

Wellness. Health promotion. Primary prevention. Quality of life. Healthy lifestyles. These terms emerge from the groundswell that is afoot in this country, felt among the general population and professional helpers alike. Every day increasingly larger numbers of people are joining the legions who are committed to leading healthy lives and avoiding sickness and disease.

The signs of this movement are all around us. A glance at the list of best selling non-fiction books will typically show, as heading those lists, books on proper nutrition, aerobic exercise methods, stress management, parenting effectiveness, childhood development, self esteem, organizational excellence, and other topics of interest to people who seem to be almost obsessed with the need for developing and maintaining personal health. Regular television fare, and that beamed by cable, consistently carry lifestyle programming. A wide range of self-instructional, self-help cassettes is available for home viewing. Self-help groups and study circles of all kinds are present in most large communities to help people not only cope better with crises and loss, but, also, to assist them to function even better than they may be presently with such issues as communication, parenting, personal growth, and so forth. The mental health establishment is providing an increasing variety of educational programs in these same general areas that are meant to strengthen the healthy functioning of participants.

Of course, none of this is without cultural and historical precedence. Consideration of common admonitions in our language is enough to illustrate: "An ounce of prevention is worth a pound of cure." "Look before you leap." "Only you can prevent forest fires." "Stop, look, and listen." "Save for a rainy day." "Be prepared." "An apple a day keeps the doctor away." These cultural dicta represent common sense, every day notions—passed from generation to generation—with which we are all familiar and accept or reject in different ways as we lead our lives. Their time-honored continuance in our language indicates the strong cultural appeal that minimizing or eliminating danger, misfortune, and emergencies hold for us.

These examples of folk wisdom each represent, at a most primitive level of conception, what activities people can perform to help insure their continued good health. Thus, we can see how people are advised to live intentionally (e.g., "be prepared"), to maintain daily good health practices (e.g., "an apple a day keeps the doctor away"), to avoid danger (e.g., "look before you leap"), and to assist in protecting the larger community (e.g., "only you can prevent forest fires").

As people engage in activities to strengthen their lives and to avoid the excessively noxious slings and arrows that await in life, they are exercising a form of *primary prevention.* That important concept occupies front and center stage, not only in this book chapter, but throughout our discussion of primary preventive counseling.

PRIMARY PREVENTION

Basic Definition

Simply put, primary prevention refers to intentional programs that target groups of currently unaffected people for purposes of helping them to continue functioning in healthy ways, free from disturbance. Primary prevention in mental health is one part of the tripartite concept of prevention itself: *primary, secondary,* and *tertiary prevention.* Where secondary prevention refers to the early detection and treatment of people with problems or disorders (e.g., individual counseling about a relationship concern), tertiary prevention refers to the rehabilitation of seriously disturbed individuals (e.g., psychotherapy for a hospitalized patient to assist in returning to the community). However, an important point to note is that when most mental health professionals today discuss "prevention," they are really referring to *primary* prevention in mental

health. They are concerned with reaching groups of people before they have developed any appreciable signs of psychological disturbance.

I want to be very clear in this book that what we are considering is indeed *primary* preventive counseling. This clarity begins with the title of the book itself and, I trust, will extend throughout. I agree with Cowen (1983) when he wrote:

> ...I would count it a major blessing and a catalyzing force in the development of primary prevention in mental health for amorphous, overinclusive terms such as "prevention" and "prevention in mental health" literally to be stricken from the vocabulary. Right now, they do more harm than good. (p. 12)

Need for Primary Prevention

George Albee, one of the important shapers of the primary prevention movement in mental health, told a story that graphically illustrates the need for primary prevention programs and services in mental health (Albee, 1986a). Invited to address a group at the Downstate Medical Center, he arrived in its inner city Bedford-Stuyvesant location. While entering the impressive building, he observed chauffeur driven, long black limousine after limousine arrive through the squalor and chaos of the surrounding inner city and pull up at the Medical Center. Out of each one, he said, would come an exquisitely dressed woman. Puzzled by this, he asked an employee what was going on? To his dismay, he learned that these upper class women were coming to keep their individual, daily psychoanalytic appointments.

He did not mean for this story to be an indictment of psychoanalysis, per se. His point was to emphasize the tragic irony found in that setting. What is this irony? It is the juxtaposition of the "have-nots" in the community with the "have's" from outside it, compounded by the provision of expensive, long duration individual psychological services to the wealthy amidst an environment of poverty, unemployment, crime, and illness. In short, the anecdote sharply illustrates the need for primary prevention in mental health: Human psychological (and other) needs far outstrip the available supply of professionally trained mental health care providers, such as counseling psychologists and professional counselors.

Another story, now quite famous, also addresses the issue of need in primary prevention. Rappaport (1972) put it this way (cited in Goodyear, 1976, p. 513):

Imagine a warm, sunny afternoon. You are in a local park, lounging indolently on a blanket, with a bottle of wine and a good book on the grassy banks of a river below a swimming area. Suddenly you hear thrashing sounds, and a cry for help from the river. Startled you look over to see a person struggling unsuccessfully as the water sweeps him away. You courageously dive in, rescue him, and then return to the serious business of soaking up the sun. There is to be no respite for you, however, for you find yourself repeating this performance with several other drowning people throughout the afternoon. As you are ministering to the final victim, an observer asks a question that is startlingly powerful in its logic and simplicity: "Would it not ultimately be much easier and less dangerous to go to the swimming area and teach those people, collectively, how to swim than to rescue each individually?"

Can we any longer afford the luxury of gearing our helping services around the model of "rescue each individually?" Wouldn't it be more efficacious to take the advice of the observer in the previous anecdote and begin to teach people collectively the competencies they need so that they can successfully cope with the demands of life later? Additionally, although the astute observer did not mention this, would it not have been useful for a railing to have been erected at the waterfall to keep the non-swimmers away from the danger of falling in and drowning? That is, as a general rule, can we begin designing environmental improvements to protect and enhance human functioning? The teaching of life competencies and the design of environmental improvements, both conducted before the onset of problem formation, represent two ways to correct what can only be described as a need/supply imbalance.

EXAMPLES OF THE NEED/SUPPLY IMBALANCE

Illustrations of the need/supply imbalance are rampant. They can be found in relation to drug and alcohol abuse, teenage pregnancy, infant mortality, nicotene addiction, child abuse, acquaintance rape, and in many other areas.

Note the following figures as examples, drawn from a variety of epidemiological studies (cited in Jason & Bogat, 1983). Approximately 18 million children annually experience the effects of parental separation or divorce. Approximately 10 million people are alcoholics in this country. Estimates of suicide range each year from 25,000 to 60,000. Of the people treated by general practitioners the estimate is that in excess of 50% are really there because of psychological difficulties.

These and other problems pose significantly serious personal and societal consequences. The resources available to address them are inadequate, especially as a traditional, individual, remedial helping model is employed.

For a closer look at this issue, let us explore two problem areas in some detail. These are the twin problems of illiteracy and school dropouts, and the problem of mental disturbance.

Illiteracy and School Dropouts

The United States is home to 20 million illiterate adults. This figure represents 13% of the adult population. As a nation, this poor literacy rate ranks us 15th in the world (Australia is first).

These illiterate adults can neither read nor write, and, therefore, find themselves at a considerable disadvantage in nearly every aspect of life in this society. If we add to this figure of 20 million illiterates those in our nation who are marginally literate (that is, they can read and write at the eighth grade level), the total of these incapacitated persons reaches 40 million. As if this is not bad enough, we are told that millions of high school graduates cannot read or write, and even many entering college students cannot adequately read, compute, and communicate (ABC, 1986).

The personal and national consequences of this problem are massive and scary. Fully 50% of American workers compute at the eighth grade level or below; 28% cannot properly change money; 13% cannot correctly address an envelope; and 33% of those eligible for the armed services are unfit to serve due to this problem.

The prevalence (i.e., the total number of current cases) of illiteracy is higher in certain areas of the United States than in others. The inner cities and certain rural sections are especially affected. In many Appalachian counties, for instance, the illiteracy rate ranges from 30 to 50%, rates that are matched in the ghettos of most large American cities. In these areas a kind of culture of illiteracy develops and gets transmitted from generation to generation. Highly correlated with illiteracy, as one might suspect, are high prevalences of unemployment, poverty, and family social disintegration.

All of this is even more tragic when one realizes that literacy competencies are essential for our rapidly changing, highly technological world. No longer are the manual industrial skills in demand, as the growing number of General Motors plant closings painfully illustrates. In the information and high-tech age, workers simply must be able to read, write, compute, and communicate effectively.

What is being accomplished in terms of training and remediation? Of the 20 million illiterates, three to four million are being reached. The remaining are not receiving either help or employment. And while the estimate is that approximately $400 is necessary to make an illiterate adult literate, in the U.S. the average expenditure per illiterate adult is $10. Given the magnitude of the problem and the relative paucity of resources devoted to attack it, the prospect of a permanent underclass of illiterates in this country is possible.

The school dropout situation is equally alarming. Nearly one million school age children are lost each and every year as dropouts. The average dropout rate across the land is 25%, and frequently rises to 50% in the inner city. The economic cost alone is appalling, amounting to around $75 billion per year in wasted lives. In Chicago, for instance, the estimate is that the 13,000 dropouts from its public schools in 1982 will cost the taxpayers $60 million a year for the next 40 years, or $2.5 billion over their lifetimes (Rowan, 1986).

These million or so dropouts from the schools in our country provide a continual supply of illiterates and marginal literates together with the psychological problems associated with and increased by illiteracy. These people tend to become the least productive and the costliest in America.

Clearly, attempts to correct the illiteracy and dropout problems by working with affected individuals—one at a time—will not put a dent in this enormous crisis. Programs of primary prevention stand a much better chance.

Mental Disturbance

Forty-three million adults in this country are mentally disturbed. This figure amounts to 19% of the adult population (Albee, 1986b; Albee & Gullotta, 1986). Not counted among these 43 million sufferers

are patients in hospitals, the homeless who roam our city streets, or children. (Children constitute another 20 million cases.)

Epidemiology (e.g., McMahon & Pugh, 1970) and psychiatric epidemiology (e.g., Freedman, 1984; Turns, 1985) present data, such as that given previously, that can help inform professional counselors and counseling psychologists about glaring human need. For instance, psychiatric epidemiological information allows one to understand the frequency with which a particular disturbance occurs in the general population, and how the prevalence of this disturbance may vary by different demographic variables, such as age, sex, and race (Watkins, Jr., & Peterson, 1986).

What patterns of mental disturbance are most prevalent? Those disorders that appear to most widely affect the population in general are alcohol abuse-dependence, phobia, drug abuse-dependence, and dysthymia. As Watkins, Jr. and Peterson observed, because these disorders seem to cut across all strata of our society, practitioners in mental health centers, college and university counseling centers, private practice, or hospitals can expect to encounter such clients with some frequency.

As shown by Albee and Gullotta (1986), only about seven million of the total adult population diagnosed with some form of mental or emotional problem were seen in the public or private mental health system, even though the prevalence rate in certain survey areas reached as high as 23.4%. Again, these data validate that most persons who are in need of psychological help are not receiving it, at least from a professional helper.

Interestingly, approximately one-third of all those who are receiving help from a mental health professional are free from any DSM-III classification. These individuals bring so-called "problems of living" concerns to their helpers: adjustment and situational problems such as marital and family concerns, identity diffusion, career choice and change quandries, and the like. These may be the kind of people to whom Shaw (1986) was referring when he wrote:

> Who are these ineffective people? They are your friends and mine. They are your relatives and mine. They are people we all know. Their suffering may not be apparent because most of them do not have obvious problems. They are unhappy or miserable people who live in constant psychological pain while attempting to live their everyday lives. They are people whose productive lives and social in-

teractions may be highly ineffective. They are that large group of people whom Thoreau was describing when he wrote, "The mass of men live lives of quiet desperation." (pp. 624-625)

Implications of the Need/Supply Imbalance

As we have seen in the problem areas of illiteracy and school dropouts and in mental disturbance, millions of people in our society are simply not receiving the kind of help they so keenly need. These are the casualties of life, those who have been unable to adequately negotiate this complex, often impersonal and uncaring society. Further, the suggestion is that the negative consequences of this unfortunate situation are felt not only by the individuals affected, but, also, by their families and the nation as a whole. As these people face a future that may be described as ranging from uncertain at the best to desperate at the worst, so, by extension, does the country. As is well known the continued health of the nation (and of the world, for that matter) is dependent on the productive functioning of effective persons, ever the more so as we hurtle head-long into the information age of high technology.

PRIMARY PREVENTION IN MENTAL HEALTH

Reliance on Traditional Services Is a No-Win Situation

Attempting to correct the millions of psychological and educational ills before us through the traditional method of individual, remedial services is a no-win proposition. It is no-win because, as we have seen, the need/supply imbalance is simply staggering. It is no-win because remedial services, such as psychotherapy, are after-the-fact approaches that can do nothing to stem the tide of new cases. It is no-win because the access to traditional clinical services is becoming increasingly more difficult and expensive as cost containment and efforts to monopolize the health care industry become commonplace. It has always been a no-win situation for the typically underserved—or nonserved—in our society, and it is becoming even more so, given the above trends. Thus, the poor, the unemployed, the culturally different, the homeless, and untold others who are most in need are least able to get help. And it is a no-win situa-

tion because professional counseling, counseling psychology, and other helping professions are restricting the list of available practitioners in their efforts to protect the consumer (and the provider) through licensing, registries, and the like.

That reliance on individual, remedial services affords "no wins" does not mean that they are "losing" approaches. Quite the contrary is the case. Individual and group counseling and psychotherapy are critically important helping modes for people who have already developed evidence of debilitation. For the people who require that approach, it is the "only game in town."

Yet, individual and group counseling and psychotherapy are *treatment* approaches that can contribute not a whit to the reduction of incidence. That is, the number of *new* cases of any psychological or educational problem (the incidence) is unaffected by treating problems that are currently being experienced by clients or patients. Said in every day language, treatment can only "patch up" the casualties, it repairs the damages already present. While problem correction is an enviable and an important goal for professional counselors, counseling psychologists, and other helpers to be engaged in, all the efforts of all the helpers in the world who are providing reparative services will not prevent the appearance of new sufferers. Indeed, this was the message contained in the "drowning person" story presented earlier.

Therefore, for those who are concerned about stemming the tide of new problem cases, the traditional palliative approaches must be supplemented by other methods that seek to lower incidence; that is, they are offered to avert problem occurrence in the first place. These programs and services are subsumed under the rubric of primary prevention in mental health.

Qualitatively Different

Cowen (1983) has stated that not only is primary prevention sorely needed in mental health practice and research, it also offers the field the "most attractive set of genuine alternatives it has ever had" (p. 14). After reviewing the so-called revolutions in mental health, from Pinel's efforts to humanely treat the mentally ill in the 18th century, to Freud's brilliant psychodynamic treatment of the neuroses, to the innovative efforts of community mental health to bring help-giving into the community, Cowen suggested that a true revolution in mental health is still to happen. While the three forces mentioned above exerted significant energy

and direction to mental health, he suggested that all of them continued the problem correction theme that we have been addressing. He concluded by declaring that primary prevention, through its strategies of building psychological health and preventing maladjustment, provides an attractive alternative to mental health's "rutted" ways, and that it very well may constitute its first true revolution.

Although a basic definition of primary prevention was provided earlier, a helpful step now will be to peruse several more expanded definitions. By so doing, you can perhaps better appreciate the ways in which this intervention differs qualitatively from past approaches in mental health.

What It Is: Definitions

Only recently have definitions of primary prevention in mental health begun to be clarified from a constant state of fuzziness. Indeed, writers over the years have decried the ambiguity associated with the concept. Is primary prevention the same as prevention? When using the term, does one mean primary prevention or primary prevention in mental health? Aren't primary and secondary prevention really the same? And, what is preventable in the first place? While to some extent the definitional problem still exists, for the most part leaders in the field seem satisfied that the approach can now be reasonably well defined.

As you read the various definitions of primary prevention that follow, all of which are quite stringent, pay special attention to what seems to be its distinguishing characteristics. Doing so will help identify what makes primary prevention qualitatively different from other mental health approaches. Appropriately, let us first of all examine a definition offered by one who is perhaps the parent of primary prevention in mental health, Gerald Caplan (1964):

> Primary prevention is a community concept. It involves lowering the rate of new cases of mental disorder in a population over a certain period by counteracting harmful circumstances before they have a chance to produce illness. It does not seek to prevent a specific person from becoming sick. Instead, it seeks to reduce the risk for a whole population so that, although some may become ill, their number will be reduced. It thus contrasts with individual-oriented psychiatry, which focuses on a single person and deals with general influences only insofar as they are combined in his (her) unique experience. (p. 26)

Goldston, who served as director of the National Institutes of Mental Health Office of Prevention from 1981 to 1985, has provided this definition of primary prevention (Goldston, 1977):

> Primary prevention encompasses those activities directed to specifically identified vulnerable high-risk groups within the community who have not been labeled as psychiatrically ill and for whom measures can be undertaken to avoid the onset of emotional disturbance and/or to enhance their level of positive mental health. Programs for the promotion of mental health are primarily educational rather than clinical in conception and operation with their ultimate goal being to increase people's capacities for dealing with crises and for taking steps to improve their own lives. (p. 27)

Bower (1963) identified the overall objectives of primary prevention as being twofold:

> (1) to reduce the incidence of new instances of emotional distress or disturbance, and (2) to promote emotional robustness. (Cited in Klein & Goldston, 1977, p. 27)

Conyne (1983) defined primary prevention this way:

> Primary prevention is (1) proactive and (2) population-based. It includes (3) anticipating potential disorder for a (4) population at risk and introducing (5) before-the-fact interventions that are delivered (6) directly or (7) indirectly. These interventions are intended to (8) reduce the incidence of the disorder by (9) counteracting harmful circumstances that contribute to it by (10) promoting emotional robustness in the population at risk so that population members are both (11) protected and (12) becomes more fully competent. (p. 332)

Cowen (1980) described it as follows:

> Programs that engineer structures, processes, situations and events that maximally benefit in scope and temporal stability, the psychological adjustment, effectiveness, happiness and coping skills of many (as yet unaffected) individuals. (p. 264)

What do these few definitions of primary prevention in mental health share? Cowen (1983) identified these structural similarities and stressed that they are prerequisites to determining whether a program is primary prevention in scope. *The primary prevention program must be before-the-fact; it must be mass- or group-oriented and not targeted to individuals; it must be directed to presently "well" people who are unaffected, or to those who are expected or known (epidemiologically) to be at risk for disturbance; and the program must be intentional,* that is, it must emerge from a knowledge base suggesting that a program's opera-

tions may likely enhance psychological health or decrease psychological distress.

Finally, the proof is in the pudding. If, indeed, the program meets all the previous rigorous criteria but fails to demonstrate preventive effects during evaluation, then the preventive aspects of the program must be suspect. Interestingly, two special issues of professional journals (*American Journal of Community Psychology,* 1982; *Journal of Counseling and Development,* 1984) have used these criteria to selectively publish research articles of primary prevention programs. You are encouraged to obtain these sources and read about those programs.

Empowerment as an Emerging Theme

If the definitional conundrum now seems completely solved, not so. Rappaport (1981), in a challenging Presidential address to the American Psychological Association's Division of Community Psychology, suggested that *empowerment* and not prevention be the guiding concept for community psychologists. He finds prevention (including primary prevention) implying experts fixing, even rescuing, people from themselves and he asserted that this model is inappropriate and ultimately defeatist. He invited us to participate with community members in jointly discovering what works naturally and what doesn't and then joining together to promote power and control in people's lives. This collaborative ethic may conflict with the discussions by others to "engineer" structures and processes, situations and events to benefit others (see, for example, the Cowen 1980 definition of primary prevention previously cited).

In another important operationalization of the empowerment concept, Rappaport (1977, 1981), Rappaport, Swift, and Hess (1984), and several contributions by Albee (e.g., 1986b), have eloquently and passionately stated the primary preventive case for becoming social activists in order to help redistribute power and influence in this society. They contend that the powerless can be aided in a truly profound way in the search for social justice through removing many of the causes of psychopathology.

For Albee, empowerment means the redistribution of power to the powerless. As he stated (Albee, 1986b):

> Psychologists must joint with persons who reject racism, sexism, colonialism, and exploitation and must find ways to redistribute social power and to increase social justice. Primary prevention research inevitably will make clear the relationship between social pathology and psychopathology and then will work to change social and political structures in the interest of social justice. It is as simple and as difficult as that. (p. 897)

The empowerment theme is a compelling one. What is unclear is whether empowerment is to be considered as a competing force to primary prevention, as Rappaport suggested, or if it is (or already was) a part of it. Resolution of this issue is in the offing.

Regardless, the theme of empowerment contains two powerful strands, as we have seen. The first addresses the ethic of collaborative participation of helpers and helpees. Here, a true spirit of working together is involved, rather than the helpers *doing something to* those in need. The second strand of empowerment is tied to system change, the rooting out of socio-political-economic cancers in the society that give rise, it is said, to psychological maladjustment. Clearly, this strand emerges from the view that a main source of individual pathology lay not inside the person but, rather, emerges from external environmental conditions, such as poverty and ill-fated laws.

What follows, then, is that empowerment must involve the collaboration of professionals with indigenous community members to produce social action, policy change, and life opportunities—rather than palliative people change—in order to realize real primary prevention (Cowen, 1985).

What will real primary prevention produce? A society free from the "isms" of social injustice: racism, ageism, sexism; a society where economic, social, and political power is diversified; and a society that accepts and nurtures its multipluralistic diversity. Advocates maintain that these healthy societal characteristics, in turn, would remove the social pathogens that foster and maintain individual illness. Thus, a healthy social structure would support healthy individuals.

Proactive and Reactive Forms

Macroenvironmental change as an empowerment strategy is articulated by Catalano (1979) and Catalano and Dooley (1980). They have stressed the importance of macroeconomic factors in producing psychological maladjustment. They are concerned with major economic

forces, such as plant closings, unemployment, and economic downturns, especially on a regional basis. Catalano and Dooley cite research data, some of which are conflicting, but the sum of which tend to validate that the status of an economy affects the psychological well-being of the population it supports.

In examining this issue, these authors differentiate between what they see as two major forms of primary prevention: Proactive and reactive. Here, the argument is not like those of old. That is, the concern is not about the proper definition for primary versus secondary versus tertiary prevention, nor is it about the difference between prevention and primary prevention. No, here the argument is about primary prevention itself, with a clear preference being given to the proactive form.

How are proactive and reactive primary prevention said to differ? As in the environmental change aspect of empowerment that we considered a moment ago, *proactive* primary prevention is used to eliminate noxious stressors present in the macroenvironment, as evidenced in the large systems of our society—for example, excessive political power, discrimination, restrictive child care policies, unequal wealth distribution, health care inequities, inadequate social security benefits and procedures, and so on. The idea behind the proactive approach is that removal of these kinds of stress sources will serve to strengthen the psychological health of the populace. As such, proactive approaches are considered "first-order" because they are used to alter the very origin of problems.

By contrast, Catalano and Dooley view *reactive* primary prevention as taking a "second-order" change approach by attempting to increase the capacity of individuals to cope more adequately with existing pathogenic environmental stressors. For instance, employees in an organization participate in a stress management program conducted in the workplace. This effort, although laudable, is intended to help these employees to adapt more satisfactorily to stressors already present, that is, to the present working conditions. Alternatively, a proactive primary prevention approach would seek to eliminate the undesirable work stressors themselves.

The basic differences between proactive and reactive approaches to primary prevention find their origins in public health practice, about which a short discussion may be useful. As Bloom (1977) showed, the emphasis in the 18th and 19th centuries on cleanliness, sanitation, and

the elimination of "miasmas" (noxious odors thought to give rise to major infectious diseases), yielded enormously positive consequences in disease prevention. The public health movement originated with the early miasmatists, those environmental and sanitary engineers who sought to prevent disease through efforts to remove and eradicate filth for total populations. Through such environmental modification projects maternal mortality, typhoid fever, yellow fever, tuberculosis, typhus, cholera, and infant mortality were all sharply reduced. The identification and elimination of causative factors in the environment continues to power public health practice today, in such issues as AIDS, smoking reduction, cancer, and cardiovascular diseases.

For instance, with regard to smoking reduction, the efforts of the Surgeon General of the United States to remove cigarettes completely from the workplace due to the overwhelming evidence that both voluntary and involuntary smoking cause a host of disease states (and death), exemplifies the historical role of public health in this country. It illustrates the soil from which proactive primary prevention grows. By contrast, smoking prevention educational programs in the school that are aimed at young children who (presumably) do not yet smoke cigarettes exemplify the reactive primary prevention approach. Following the thinking of Catalano and Dooley, these programs are reactive because they do not attack the environmental source of the problem (cigarettes themselves), but attempt to augment the resistance of the young people to smoke through educational efforts.

What must be noted is that *both* proactive and reactive approaches are primary prevention. The difference is not in the timing of when they are offered, or in their goals of increasing health and decreasing disturbance. The cleavage, which is not always clear-cut, hinges on the designation of the target for change: Are the basic environmental conditions that are thought to produce psychological problems targeted, or is it the people who might later experience these problems?

The proactive approach to primary prevention in mental health (Catalano & Dooley, 1980) and the empowerment perspective (Albee, 1986b; Rappaport, 1981) both give priority to basic, macroenvironmental change as the sine qua non to eliminating the causal elements and pro-

cesses of psychological disturbance, thus maximizing human psychological health. Others (such as Bower, 1963; Cowen, 1983) hold that both environmental and personal change are important in this effort.

TWO APPROACHES

Let us turn now to an exploration of primary prevention in mental health through the twin methods of environmental and personal change. This discussion will be guided largely by the work of Cowen (1985) on "person-centered" and "system-centered" approaches to primary prevention in mental health. I believe devoting considerable attention especially to the person-centered orientation is very important for professional counselors and counseling psychologists. The person-centered orientation validates a conceptual framework that these helpers should find compatible. Further, it signifies methods that they can put to use in what we shall come to call in this book, "primary preventive counseling."

As you have seen, primary prevention in mental health can be sought through two main strategies. The first of these strategies, "system-centered change," involves either eradicating or minimizing the apparent environmental sources of stress. It emphasizes macro-level change in such conditions as wealth distribution, and the ending of various forms of discrimination. These efforts are thought to be empowering of individuals. The second major strategy, "person change" involves helping to strengthen the capacity of people to resist future stressful situations and events. Here, the adaptive, coping resources of people who are thought to be at some risk for developing debilitating psychological problems are increased through educational and informational approaches. This second strategy has been referred to by Catalano and Dooley and by Rappaport as a type of reactive primary prevention.

Cowen (1985) has elaborated the primary prevention in mental health schemata further. My adaptation of his conceptualization is sketched is Chart 1.1.

Approach	System-Centered Change	Person-Centered Change
Focus	Macro-reform (Proactive & Empowering)	A. Situational (Reactive) B. Competency-Enhancement (Proactive & Empowering)

Chart 1.1. Primary prevention in mental health.

This conceptualization invites discussion for two main reasons. First, it includes within the overall person-change approach a *situational* focus. This innovation greatly broadens previous notions which tended to restrict person change to the change of persons, apart from their situational contexts. Additionally, in previous conceptions, situational change was viewed as a form of system change. It now becomes realistic to identify people-in-settings and transitional life situations as a target for a person-centered approach to primary prevention.

Secondly, as we will see shortly, Cowen allowed in this model for one form of the person change approach, competency-enhancement, to be designated as a *proactive, empowering* focus for primary prevention in mental health. Past definitions have tied the proactive and empowering appellations to macro-reform, or large scale economic and social change strategies.

Both of these adaptations present significant practical implications for the involvement of professional counselors and counseling psychologists. I will address this point toward the end of this chapter and, then, regularly throughout this book.

SYSTEM-CENTERED APPROACH

One can provide no argument that the system-centered approach to primary prevention in mental health, as compared with the person-centered, affords the greater potential for promoting health and eliminating dysfunction among individuals. This is so because the elimination of the underlying conditions that serve to dehumanize and disenfranchize people from participation in the full range of possible options in this society would release human potential rather than squash it, with accompanying positive physical and psychological benefits. At least this is the (perhaps Utopian) vision which undergrids the system-centered approach. Working toward improving the major sub-systems of society, such as job opportunities, justice, education, housing, health care, and the like needs to be continued, if not intensified.

Simultaneously, methods for how counseling practitioners can become more effective as system change agents are desperately required. How can social action be accomplished? How can policy change be fostered and maintained? How can the legislative process be affected more consistently and directly? How can cultural diversity become fully woven into the fabric of how we in this society think, feel, and act? In short, a terribly complex and challenging question requires answering: How can the barriers to an involved life be replaced by opportunities for the same? These methods need to be discovered and put into place so that counseling psychologists and professional counselors can broaden their effectiveness beyond person-change approaches.

Of course, some accomplishments in the system-centered arena have occurred already. New roles have emerged for psychologists and professional counselors to use in advancing human public policy (see, e.g., Task Force on Psychology and Public Policy, 1986). These roles include those of expert witness in the courts, serving as a legislative staff assistant, research disseminator, administrator, and activist-collaborator. The opportunity in each of these roles is to apply knowledge of person-environment behavior so as to promote wide-spread human betterment.

A number of methods are being used to exert influence at the system level. The major psychology and counseling professional organizations of the American Psychological Association and the American Association for Counseling and Development, respectively, are increasing their press on the legislative process through advocacy and the filing of amicus briefs in support of mental health issues in the courts. Esteemed members of the professional counseling and counseling psychology professions have been called upon at various times to serve on high-level state and national level advisory committees that address issues of importance to education and mental health, such as former President Carter's Commission on Mental Health (1978). In the media, a number of professional organizations have been involved in public mental health education. For instance, The American School Counselors Association (a division of the American Association for Counseling and Development) participated in a national telephone "back-to-school" hotline sponsored by *USA Today* (August 26-27, 1986). More than 900 telephone calls were fielded by 29 counselors during this time, in conjunction with a week-long series of articles published on the school situation by the nationwide weekly newspaper. Through these public education methods, parents, students, relatives, and interested others received information about their concerns in such areas as preventing drug use, study habits, motivating techniques, childhood stress, parent-child communication, and back-to-school clothing.

As impressive and urgent as these kind of system-centered involvements are, only a small number of professionals are participating. Greatly increasing efforts to produce broad, system change should be a first-order goal in pursuing primary prevention in mental health (Elias, in press).

PERSON-CENTERED APPROACH

Effectively expanding the role of counseling practitioners in the system-centered approach is, perhaps, a longer-term goal. A more immediate one is to extend the involvement of these professionals in the range of person-centered approaches to primary prevention in mental health. This latter constellation of interventions offers the most promise for the general participation of counseling psychologists and professional counselors in the primary prevention in mental health universe.

First, a caveat is in order. The term, "person-centered" has a hallowed tradition in counseling and psychotherapy. Originally called "non-directive," and then "client-centered," the person-centered counseling and psychotherapy of Carl Rogers has been a dominant theoretical and applied force since 1942 when he published *Counseling and Psychotherapy* (Rogers, 1942). This individual and group method has been translated and used, also, in teaching and consulting. Briefly, person-centered counseling refers to a psychological helping procedure that makes heavy use of the helper-helpee relationship to enable the helpee to increase in the kind of self-awareness that can lead to congruent personal change. This meaning of the term, "person-centered" should not be confused with the form of primary prevention in mental health to be considered in the following material.

As suggested in Chart 1.1, two categories of person-centered primary prevention interventions are possible: (1) those that are situation-focused, and (2) those that are focused on competency-enhancement. Let us turn now to an examination of these two categories of interventions.

Situation-Focused Interventions

Counseling psychology and professional counseling have evolved around the individual. As you have read, individual change has dominated the helping approach by both clinical and counseling practitioners.

Counter movement in psychology has occurred throughout this historical development, but never to claim a substantial beachhead. Contrarians such as Kurt Lewin (e.g., 1936), Roger Barker (1968), George Stern (1970), and Rudolf Moos and associates (e.g., 1979) have whittled away at the dominant "intraindividual" approach with variations on a different theme. This theme has been referred to as that of person-environment, people-in-context, and the ecological perspective, among others. Regardless of the label used, the common theme supplants the "self-contained individual" interpretation of behavior (Sarason, 1981, pp. 835-36) with the notion that situational constraints and supports are important influences of human functioning.

This situational approach has been researched extensively by Dohrenwend and Dohrenwend (e.g., 1974) and discussed by many others, such as Price (1974), Bloom (1979), Conyne (1981), Felner,

Farber, and Primavera (1983), and Schlossberg (1981). The quest here is to discover what stressful life situations or events appear to trigger patterns of dysfunctional behavior in those people exposed to them. This information can then be used to develop primary prevention interventions that are aimed at high risk *situations*, rather than at high risk *populations* (Price, Bader, & Ketterer, 1980).

For example, divorce is clearly a high risk situation for the divorcing parents and for any children. So is the loss of a job, being the child of an alcoholic, working in a high pressure and ambiguous work setting, the transition from high school to college, loss of a loved one, and surviving a natural disaster such as an earthquake. Also clearly, although these are all high risk situations, different individuals experiencing them will not all respond the same—some may withdraw, others may begin to drink heavily, others may put on lots of weight, and some may even thrive. Stress is the common factor in these situations that may precipitate a variety of problem reactions in those who experience them. And the stressful life situations themselves can be targeted for primary prevention intervention.

As you can see from the previous examples, some of these stressful life situations could be classified as involving long-term evolution; the child of an alcoholic might typify this kind. Others represent relatively sudden events that trigger generally predictable reactions in those experiencing them; a neighboring family I know is right now attempting to cope with a dying family member. And then natural disasters, the so-called "Acts of God," periodically hit like lightningbolts to dislodge the lives of those affected; a volcano erupts, or a plan crashes in a densely populated urban neighborhood. Finally, ever more frequently, planned disasters are occurring ("Acts of the Devil?"), to shock the world; a terrorist bomb explodes in an airport, or a fired employee goes out of control killing or wounding many former colleagues.

In this person-centered approach to primary prevention in mental health, the situation foretells and guides the intervention. That is, people who are about to experience such a stressful life situation, or who are in the very early stage of its evolution, are brought to experience an intervention that is designed to foster supportive processes and to build useable problem solving skills that are sensitive to the situation at hand. Thus, *life situation* primary preventive programs in mental health are being found useful for helping people to cope more adequately with difficult life transitions, such as in helping children of divorce (e.g., Pedro-

Carroll, 1983), as well as newly divorcing adults (e.g., Bloom, Hodges, & Caldwell, 1982) cope better with their changing lives.

Support groups, if organized early enough, afford another useful alternative to aid in the primary prevention of later dysfunction. These groups may involve the participation of a professional helper (e.g., Pearson, 1985), or they may consist totally of lay persons who hold a mutual motivation to better resist the potentially negative consequences inherent in the situation. These latter are often called "self-help" groups or "mutual help" groups (Silverman, 1985). The purpose of all these support groups is to create a resource-sharing environment. In such an environment, participants can obtain valuable information while connecting meaningfully with others who are experiencing a similar difficult life situation. Examples of these types of support groups include those for parent education about drug prevention, study groups on practical topics such as financial management or single parenting for the newly divorced, and death and dying support groups for those who are soon to experience the loss of a loved one.

Early crisis intervention (Caplan, 1964) offers yet another means for a situational form of primary prevention. For instance, a team of psychologists has been sent to crisis intervene immediately in two national tragedies recently, the McDonald's mass murder in California and the post office slaughter in Texas. Similarly, this type of crisis intervention has occurred following natural disasters, such as in tornado and earthquake sites. The intent in these efforts is to treat the crisis as an intense opportunity for producing rapid and positive adaptation and growth, thereby reducing the trauma and enhancing positive coping behavior.

Whatever the situational primary prevention intervention program, it is ushered in by the precipitating situation. Therefore, it is rightfully viewed as a type of reactive primary prevention in mental health, as is shown in Chart 1.1. In fact, in some cases, the situational form of primary prevention may bleed over into secondary prevention, since precisely determining when presently healthy behavior becomes dysfunctional is impossible to do. The "mixing" of primary and secondary prevention approaches becomes increasingly more possible when dealing with evolutionary life situations, such as in children of alcoholics, schizophrenics, or divorce, Despite this untidiness, the situational intervention holds much primary preventive potential, and it commands an important place in the primary prevention in mental health armamentarium.

Let us now examine a proactive form of person-centered primary prevention, which Cowen (1985) labeled as "competency enhancement." It offers the greatest immediate potential for today's counseling practitioners.

Competency-Enhancement Interventions

This category of person-centered interventions differs qualitatively from those of the situationally-centered, discussed in the previous section. According to Cowen (1985, p. 33), the competency-enhancement interventions are proactive, as compared with reactive, because they are used to "...provide relevant skills and competencies to as yet unaffected groups to strengthen their adaptive capacities."

Note that the claim that this category of primary prevention in mental health interventions is either proactive or empowering is a matter of some debate. As we have seen, Rappaport (1981) viewed the teaching of life skills as name trading with psychotherapy, a kind of "old wine in new bottles," and another example of the mental health establishment taking control over people. And Catalano and Dooley (1980) would most likely gauge competency-based efforts as reactive. Cowen and others who advocate for a competency-based perspective in primary prevention (e.g., Danish, Galambos, & Laquatra, 1983), would seem to disagree. They maintain that targeting well people in order to assist them to develop important life skills, such as goal setting, problem solving, and developing action plans is, by definition, an empowering and proactive act. Indeed, this understanding of empowering is what I used in subtitling this book: *Empowering* People and Systems."

Setting that controversy aside, let us examine the competency-enhancement approach, using Cowen's analysis (1985) as a guide. After considering the following section, you may wish to form an opinion about this issue.

Microsocial Change

The tenet here is that the life competencies of people can be advanced through the positive alteration of settings within which they frequently interact. Major settings in this society include the family, work, school, religious centers (churches, synagogues, mosques, and the like), and community agencies (such as prisons, hospitals, mental health centers, etc.). While each of these does not constitute the macrosocial environment, or total environment, each of these microsocial units is a

powerful and continuing shaper of human behavior—and not always for the good.

In the previous section on situational approaches, various authors were mentioned as bringing a situational perspective to mental health practice and research. Indeed, this influence perhaps is most strongly felt in the area of microsocial change. The basic Lewinian notion that behavior results from an interaction of people with their environment provides considerable theoretical and practical direction for microsocial change. It gives rise, for example, to social ecology efforts in this area.

Moos and his associates (e.g., Insel & Moos, 1974; Moos, 1979) have developed a social ecology approach to microsocial change. Its major practical application to date is the set of social climate scales that have been created for use in a wide variety of settings: families, school classrooms, university residence halls, work groups, correctional facilities, hospitals, and so on. Although developed specifically to assess the social climates of each particular setting, all the measures are based on the same three dimensions: (1) perceived opportunities for personal growth; (2) perceived opportunities for relationships; and (3) system maintenance and system change processes perceived to be present in the setting. Data which emerge from a social ecological assessment of a setting are then used collaboratively by an action researcher and setting members (e.g., members of a family, or of a work organization) to seek positive change in the setting, not in the people. For instance, in an organization, restrictive policies and procedures might be relaxed or redefined and increased opportunities for staff development may be created and supported. When successfully accomplished, such change is thought to free members to use their existing competencies more fully, or to develop additional ones.

Training in Specific Competencies

This form of competency enhancement departs from much previous work in social skill deficit training, that is, teaching people the skills they either do not possess but need or teaching them skills they incorrectly perform. Rather, here the approach is to teach "wellness" competencies, if you will, so that present personal competencies are further enhanced. In this sense, competency-enhancement training is very much in accord with the companion movements that are occurring in our society today, referred to variously as wellness, health promotion and lifestyling.

The uniqueness of competency-enhancement training in primary prevention, however, is that the concept of "at risk" guides the activity. Training programs are carefully designed and delivered to groups of currently well people who are thought to be at risk (developmentally or situationally) for experiencing future dysfunction. Thus, the competency-enhancement training program is used intentionally to prevent future discord in an identified group or setting, and it is administered in such a way that program effects are determinable. While wellness and health promotion programs share much of this same approach, they often are more broadly delivered, with the idea that "anyone can benefit."

Work in interpersonal cognitive problem solving (ICPS) (e.g., Heppner, Neal, & Larson, 1984; Spivack, Platt, & Shure, 1976; Shure, Spivack, & Gordon, 1973) and in a related intervention called social problem solving (SPS) (e.g., Durlak, 1983; Elias, Gara, Ubriaco, Rothbaum, Clabby, & Shuyler, 1986) illustrate the competency enhancement training approach. ICPS, for example, has been taught by trained college students, parents, and teachers to Head Start children, using a structured curriculum that addressed such competencies as generating alternative solutions to interpersonal problems, taking the role of the other, and doing step-by-step planning. Although not always consistent, research evidence generally documents that these children, compared with controls, were able to reduce their psychological problems and to increase their adjustment.

In a different approach to competency enhancement training, Danish et al. (1983) reported using an educational model in the schools to teach life development skills. These skills include goal setting, knowledge acquisition, decision making, risk assessment, creation of social support, and the planning of skill development. In a similar vein, Botvin and Dusenbury (In Press) have developed a Life Skills Training program to teach a broad range of personal and social skills to prevent adolescent substance abuse. Others, such as Egan (e.g., 1977) and Gazda (e.g., 1973), have designed similar programs in human relations skill training that are intended for use with certain populations. Chapter 3 will expand on these kinds of approaches which I have collectively labeled, "psychoeducational skill development."

Competency-Facilitating Experiences

Being actively involved in a facilitating experience has been shown to build competence, also. The "helper-therapy" principle (Riessman, 1965) explains this phenomenon. It holds that people can help themselves by being genuinely helpful to others in need.

I have seen this principle operate many times with college student paraprofessionals who function in a variety of helping roles—as tutors, academic advisors, residence hall advisors, alcohol education peer helpers, and so on. When I work with these student helpers, although I cannot always be sure their helpees are benefitting, I am usually certain that the helpers are.

As these college student helpers work with needy students they become actively involved, also, in the process of their own education and development and they tend to develop a closer bonding to the college or university of which they are a part. A growing body of research in higher education is coalescing to indicate that it is this process of active involvement in the campus environment that contributes significantly to the satisfaction students feel about their education and which serves to lower the attrition from the institution (Astin, 1984; Noel, Levitz, & Saluri, 1985; Pascarella, 1986). Such reduction in attrition or, stated positively, improved retention, qualifies as a primary prevention goal, especially so when high risk students are retained.

Numerous other examples could be cited to illustrate competency-facilitating experiences. The elderly who volunteer as child care helpers; the high risk dropouts who tutor others; and the candy stripers giving of themselves in hospitals across the land. The message is a very satisfying one: The capacity for self-help is present when one chooses to give help to others, thus building competencies almost as a by-product.

These three forms of competency-enhancement approaches—micro-social change, skill training, and facilitating experiences—offer special promise for psychologists and professional counselors as they pursue primary prevention in mental health and education. As *person*-centered avenues to promoting health and lowering disturbance, they lay well within the general orientation, education and training, and role definition of the broadest range of professional counseling practitioners.

SUMMARY

Primary prevention in mental health is a foundation for primary preventive counseling. It undergirds efforts taken by counseling practitioners and other helpers to enhance health and diminish disturbance. These efforts, you will come to know, are to be described as primary preventive counseling.

As you have seen in this chapter, counseling psychologists, professional counselors, and other helpers need to expand their helping repertoire beyond the individual, reparative model that has predominated historically and which still prevails today. Failing to do so may have grave consequences for this society as human needs far outstrip the available helping resources.

Primary prevention in mental health offers perhaps the best hope ever for rearranging the mental health landscape. Based on before-the-fact, group-oriented, educational and health-building interventions, it affords a break with the passive, problem-reduction model to which we have all become so accustomed. The variety of primary prevention in mental health interventions, organized under the rubric of system-centered and person-centered approaches (Cowen, 1985), can be used to lower the incidence (the number of *new* cases) of a designated problem. This may be the tool we need to begin stemming the tide against the sea of untreated difficulties that swells higher with each passing day. And, as we noticed at the beginning of this chapter, the sign of the times is right now for advancing a helping strategy whose premises are lodged firmly in health and wellness.

How counseling psychologists and professional counselors can integrate this perspective with their own established legacies becomes the subject of Chapters 2 and 3. By doing so effectively, these professional helpers can greatly multiply their power as health stimulators in this society.

ISSUES FOR REFLECTION AND DISCUSSION

1. Why is the concept "rescue each individually" a "no-win" situation, incompatible with the present need/supply balance in mental health? Give some examples.

2. References were made to the primary prevention concept of "incidence." Define it and indicate why it is so important for primary prevention in mental health.

3. Why does Cowen maintain that primary prevention offers mental health "the most attractive set of genuine alternatives it has ever had?" How does it differ from the past? What is its special promise said to be?

4. Several stringent definitions of primary prevention were given in this chapter. How was it defined by Caplan? By Goldston? By Bower? By Conyne? By Cowen? What do they hold in common? In your own words, how do you define it?

5. What is meant by the concept of "empowerment" and how does it relate to primary prevention?

6. Catalano and Dooley have differentiated reactive and proactive primary prevention. What do they see as the difference? Give an example of each type.

7. The system-centered and person-centered model of Cowen (1985) was used to organize much of this chapter, as you know. What does he mean by system-centered primary prevention? By person-centered approaches? Can you give an example of each form?

8. System-centered primary prevention holds much primary prevention potential but is difficult to undertake. Explain both aspects of this statement, identifying some ways that professional counselors and psychologists can try to effect system change.

9. Person-centered change in primary prevention is different from the person-centered counseling of Carl Rogers. Please explain.

10. Person-centered work in primary prevention is sub-divided into situation-focused and competency enhancement efforts. In general, how is each effort conducted? Give an illustration of each one.

11. Regarding competency enhancement, why might Catalano and Dooley consider it to be reactive rather than proactive primary prevention?

12. What is meant by the competency enhancement approach of microsocial change and how can it be carried out?

13. How does the primary prevention concept of "at risk" relate to training in specific competencies? How does it vary from the concept of "anyone can benefit?" Give an example of each of these general approaches.

14. Have you ever been involved in what could be thought of as a "competency-facilitating experience?" If so, what was it?

15. How does *primary* prevention differ from *secondary* and from *tertiary* prevention?

HIGHLY RECOMMENDED SUPPLEMENTARY READINGS

Albee, G. (1986b). Toward a just society: Lessons from observations on the primary prevention of psychopathology. *American Psychologist, 41,* 891-898.

> In this article, Albee, who is one of the prime movers behind primary prevention in mental health, explains why system-level change is critical to primary prevention efforts, and how social justice can be increased through redistribution of social power.

Albee, G., & Joffe, J. (Eds.). (1977). *Primary prevention of psychopathology. Vol. 1: The issues.* Hanover, N.H.: The University Press of New England.

> This volume, and the other annual books emerging from the Vermont Conference on the Primary Prevention of Psychopathology, document current trends and progress in this field.

Caplan, G. (1964). *Principles of preventive psychiatry.* New York: Basic Books.

For the initial thinking on the subject of primary prevention in mental health, turn to this book.

Cowen, E. (1985). Person-centered approaches to primary prevention in mental health: Situation-focused and competence-enhancement. *American Journal of Community Psychology, 13,* 31-49

Cowen, another important thinker in primary prevention in mental health, develops a very useful framework in this article for conceptualizing what he calls "person-centered" approaches in primary prevention. He details their empowerment capabilities and provides ample examples. The contents of this article are especially promising for professional counselors and counseling psychologists.

Felner, R., Jason, L., Moritsugu, J., & Farber, S. (Eds.). (1983). *Preventive psychology: Theory, research, and practice.* New York: Pergamon.

This compendium summarizes "preventive psychology" into six major areas: perspectives, competence-based, ecological and environmental, life stress, community practice, and future training. It provides an excellent status report of the field.

Klein, D., & Goldston, S. (Eds.). (1977). *Primary prevention: An idea whose time has come.* Washington, D.C.: DHEW No. (ADM)77-447.

The published proceedings of the Pilot Conference on Primary Prevention, this book was an early "call to arms" for primary prevention in mental health. It contains some important and useful articles.

Price, R., Ketterer, R., & Bader, B. (Eds.). (1980). *Prevention in mental health.* Beverly Hills, CA: Sage.

Part of the series on community mental health, this volume covers a wide spectrum of research, policy, and practice in mental health prevention.

Rappaport, J. (1981). In praise of paradox: A social policy of empowerment over prevention. *American Journal of Community Psychology, 9,* 1-25.

This article is based on Rappaport's 1980 Presidential address to the APA Division of Community Psychology. It called for new emphasis in community psychology, replacing primary prevention with the concept of "empowerment." It is a bold and stimulating statement.

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CHAPTER 2

A HISTORY OF AMBIVALENCE

Discovering who we are, our identity, is a basic continuing task for each of us. While this process is neverending throughout the course of our lives, it is experienced most strongly during the years of adolescence. For it is those years where we begin to experiment with the new, test and evaluate the old, and try to forge a workable and meaningful pattern that fits comfortably, is effective, and contributes to the common good. This relatively consistent pattern also defines us, giving each of us our unique, personal stamp.

As with individuals, so it is similarly with professions, organizations, and technologies. They, too, tend to proceed through developmental stages, from the simple to the complex and, perhaps, back again, evolving to meet changing demands that arise from both internal and external forces.

Counseling psychology, professional counseling, and the place of primary prevention in each of them, typifies this evolution. To appreciate this situation, a necessary step is to briefly review some of the historical developments in these professions that hold particular importance for prevention.

PRIMARY PREVENTIVE FOUNDATIONS

The origins for primary prevention in counseling psychology and profesional counseling are found in the vocational guidance and settlement house movements that took place during the early 1900s, in the mental health and hygiene movement that occurred at about the same time, in the psychometric work of the depression and World War II, and in the psychotherapy emphasis that emerged in the 1930s. Ironically, the immensely positive contribution of Carl Rogers in 1942 and 1951 (Rogers, 1942, 1951) to the psychotherapy field may have served to forestall the continued development of prevention in counseling to this day.

The thousands of immigrants to this country in the early 1900s, coupled with the forces of industrialization and urbanization, presented a host of opportunities and problems. Poverty, disease, overcrowding, and unemployment were among the many forms of human suffering that resulted.

A variety of social reform approaches were instituted to address these social problems. Among these were charities, settlement houses, and government bureaus. Vocational guidance played an important role, also.

After a lifetime of involvement with education and social reform (Zytowski, 1985), in 1908 Frank Parsons both founded the Vocational Guidance Bureau of Boston—and died. His watershed book, *Choosing a Vocation* (Parsons, 1909), was assembled following his death from various notes, dictation, and newspaper cases he had published previously. His book provided the statement around which vocational guidance efforts around the country could rally in their respective attempts to assist both the individual and society.

As Ohlsen (1983) pointed out, Parsons attracted the support of social reformers and the working class alike for his vocational guidance cause because of its underlying concern for matching the needs of the prospective worker with those of society. A proper match, it was thought, would place workers in positions that fit them well. Moreover, such a match would allow workers to contribute better to the resolution of pressing social problems.

As a type of social reform, the vocational guidance of Parsons can be viewed as a precursor to primary prevention in counseling. As well, its concern with people and work would serve to provide a focus for counseling psychology that continues to this day.

Simultaneous with the developmental of vocational guidance, mental health and hygiene emerged as a full-fledged movement. It was spearheaded by the publishing of Clifford Beers' autobiography, *The Mind That Found Itself* (Beers, 1908). The intent of this effort was to broadly inform the public about mental illness, to get them involved in alleviating its sources, and to improve treatment facilities. Thus, the psychologists and psychiatrists who were leading this cause became actively involved in disseminating informational material about mental hygiene to the public. Pamphlets, teacher education training curricula, speeches, newspaper articles and columns, and psychological services in the schools were all used heavily.

The period between World Wars I and II saw an abundance of educational and informational material reaching the public. Considerable interest was shown in these materials, especially by parents. This interest in informing the public about mental hygiene extended to other areas, as well. Psychologists wrote in the available media about improving industrial efficiency, public speaking, selling and other topics of public interest. In fact, according to Benjamin, Jr. (1986), "...by the beginning of the 1920's, much of the American public seemed convinced that the science of psychology held the keys to prosperity and happiness" (p. 943). They appeared eager to incorporate psychology into their lives.

This hunger for things psychological would dissipate by the end of the 1920s. "Pop" psychology would be largely dismissed as promising much but delivering little, thus leading to a questioning of the value of applied psychology in solving society's problems. Despite this failure, the mental hygiene movement and the related efforts to popularize psychology in the 1920s, served to set an important precedence for the informational and educational role of prevention in counseling.

With the economic depression of the 1930s came a strong need to emphasize job placement for the large ranks of the unemployed. The development and use of psychological tests, or psychometrics, emerged as an important aspect of vocational guidance at that time. This contribution would become greatly enlarged during the World War II yet to come. Thus, psychological testing, occupational information, and

retraining all became methods of returning the adult unemployed to the work force.

The innovation of psychological testing led to the beginnings of a tension that would be expressed within counseling psychology and counseling to this day: whether educational or psychological methods would predominate. Despite the conflict that it would introduce, psychological testing provided yet another foundation for primary prevention in counseling psychology and professional counseling. It provided the basic technology that would be adapted later in identifying at risk target groups for primary prevention programs and for determining if those programs were effective.

During this time, also, the psychotherapy emphasis grew in momentum. The psychoanalytic work of Sigmund Freud, and that of his adapters, such as Alfred Adler and Carl Jung, were fueling the intrapsychic psychotherapeutic efforts of theorists and practitioners in this country. Due to the shortage of helping professionals in World War II, clinical psychologists, up to that time functioning primarily as psychological examiners, filled the void for psychotherapists (Watkins, Jr., 1983a). These two functions, as psychometrist and psychotherapist, continue to dominate the work of clinical psychologists today.

A seminal publication by Carl Rogers, *Counseling and Psychotherapy* (Rogers, 1942), greatly extended this interest in psychotherapeutic procedures. Counseling and psychotherapy would eventually overtake the pursuit of psychometrics (Super, 1955) and reorient the direction of clinical and counseling psychology practice. It captured the democratic spirit of America and translated its spirit to the helping endeavor. Along with *The Dynamics of Vocational Development* (Super, 1942), Rogers' book allowed vocational counselors to focus on the process of counseling and on the unity of the person, as opposed to working on a set of isolated problems.

Concepts and techniques contained in Super's book marked the first official use of the terms, "counseling psychology" and "counseling psychologist." The June, 1952 issue of the *American Psychologist* documented these terms for the first time (Super, 1955).

At the same time, this important contribution by Rogers (and his of 1951, also) may have helped mightily to redirect the development of

counseling psychology and profesional counseling from their preventive origins, setting them on a remedial course. In fact, Aubrey (1982) described Rogers' effect on guidance and counseling as having a "steamroller impact" (p. 202). Client-centered counseling and psychotherapy, as it was called then, was intuitively attractive. It helped to pave the way for introducing a gamut of psychological helping services to the populace, all of which were based generally on an individual, remedial mode of delivery.

And so a kind of schism developed in the historical evolution of the counseling professions. Both emerged from the social impetus of vocational guidance in the early 1900s, providing a definite prevention direction. This prevention direction continues to this day, though somewhat muted. However, following the advent of non-directive counseling in the 1940s, a second more dominant direction took hold. This one commands the upper-hand today and it is typified by an individual, clinical, remedial focus.

This schism has never been mended. Its presence has served to keep development arrested at the adolescent stage. Therefore, the identity of the counseling professions has been, and continues to be, either (take your pick): (1) fluid, allowing for the fostering of considerable diversity; or (2) confused, uncertain, and weak.

This inability to decide has plagued each of the major professional organizations in counseling, the Division of Counseling Psychology of the American Psychological Association, and the American Association for Counseling and Development (until 1983, the American Personnel and Guidance Association). Throughout the history of these two organizations their leaders have grappled with the same issue: "What is counseling?" Central to this issue have been two recurring questions: Is counseling primarily an educational or a clinical activity? And, is counseling primarily preventive or remedial in focus? The resolution of these matters is critical to the present and future role for primary prevention in counseling professions.

Educational or Clinical?

In a comprehensive review of the comparative relationship of counseling and clinical psychology, Watkins, Jr. (1983a) concluded that the two specialities are presently converging more and diverging less. Levy (1984) went farther, suggesting that clinical psychology and all

other professional psychology specialties concerned with the promotion of human well-being through the treatment and prevention of psychological and physical disorders should merge under the rubric of "human services psychology." Watkins, Jr. (1985), perceiving the trends in clinical and counseling psychology to be on the same general path, reluctantly considered the ultimate integration of these heretofore separate specialties to be a foregone conclusion. The issue for him is not if, but how and when, this will occur.

The focus for this convergence appears to be two-fold: (1) professionals in both specialties are perceiving themselves as psychotherapists to normally functioning individuals as well as to those with psychological disturbance, even though counseling and clinical psychology practitioners still tend to identify clients functioning on opposite ends of the health-disturbance continuum as their primary target populations (Tipton, 1983), and (2) clinical psychology's remedial role is being increasingly tempered by prevention (Gazda, 1986; Lorion & Stenmark, 1984), while counseling psychology's preventive and vocational roles are blending increasingly with remediation (Watkins, Jr., 1985). Commenting on this situation, McNeil (1986) sarcastically observes that counseling psychology's commitment to prevention got lost in the array of its more "valued" activities of individual remedial counseling and psychotherapy.

According to Watkins, Jr. (1983a), counseling psychologists are currently decreasing their historic emphasis on vocational assessment and vocational counseling; increasing the provision of psychotherapy and psychodiagnostics; and promoting the emerging role of the psychoeducator (which will be discussed later in this chapter). Interestingly, the first two trends operationalize the clinical model while the last, the psychoeducator role, illustrates the educational model. In terms of primary prevention, one-third of the pie is a relatively small portion.

Indeed, this disproportionate emphasis has prevailed since at least the renaming in 1953 of the Division of Counseling and Guidance of the American Psychological Association (APA) to its current name, the Division of Counseling Psychology. This was a significant organizational change that would prove to hold great significance for the future development of counseling psychology and professional counseling. It served to nail down the existing controversy between the guidance and personnel advocates in the Division and those of psychology in definitive support of the latter. Doing so at least tacitly endorsed the more focused

counseling and clinical pursuit over the broader range of guidance. By so doing, the preventive hammer of guidance lost its clout.

Moreover, just one year before that, in 1952, the "rival" counseling organization was created. As Herr (1985) has written, The American Personnel and Guidance Association (now the American Association for Counseling and Development) was established from an amalgam of the powerful National Vocational Guidance Association with the American College Personnel Association, along with the cooperation of the Association of Guidance and Counselor Trainers (now the Association for Counselor Education and Supervision) and the Student Personnel Association for Teacher Education (now the Association for Humanistic Education and Development). The change in title of this organization from the American Personnel and Guidance Association (APGA) to the American Association for Counseling and Development (AACD) reflects a greater emphasis on counseling and individual development, as opposed to guidance, and it serves to place AACD in more direct competition with the Division of Counseling Psychology of APA.

These events splintered the counseling profession into two separate, yet overlapping, camps: to the more scientific- and clinically-oriented camp of counseling psychology (APA) and to the more practitioner- and educationally-oriented camp of professional counseling (APGA). While the existence of these two organizations provides an important frame of reference for their respective members, some of whom hold joint membership, their presence exacerbates confusion around the educational versus clinical issue.

Prevention or Remediation?

Further complexity can be found when one considers the existence within APA of the Division of Community Psychology. Founded in 1965 as an outgrowth of the Swampscott Conference, this Division was established to support the development of training necessary for psychologists to participate effectively in the emerging community mental health movement. This movement took its impetus from the Community Mental Health Centers Act of 1963 which, in effect, was intended to replace the medical model with primary prevention. These new preventive services were to be delivered in community mental health centers through crisis intervention, and consultation and education approaches.

Moreover, the role of the community psychologist was conceived to be dealing with normal people, not with pathology. As Bennett recorded, "the community psychologist is fully committed to furthering normal development. His (sic) procedures may have little or nothing to do with disease or disablement" (1965, p. 833). One wonders how this community psychologist role differs from that of counseling psychologists or professional counselors?

An answer seems to be that community psychology, although fraught with its own definitional problems (e.g., witness the primary prevention versus empowerment discussion in Chapter 1), seems to have embraced a before-the-fact intervention strategy to working with the already well population. Counseling psychology and professional counseling, however, have tended to hold on to their fascination with an individual, problem-reduction approach. As Hansen (1981) pointed out, "The goals might be similar, but the means were drastically different. 'Prevention' here was not used to mean interventions prior to symptomology, but rather early delivery of counseling services to individual clients" (p. 59).

Therefore, counseling psychology finds itself today between a rock and a hard place, lodged uncomfortably between the primary prevention focus of community psychology and the remedial focus of clinical psychology. As well, it is flanked by its competitive cousin, professional counseling, which itself is experiencing a prevention-remediation pull. Hansen's argument (1981) that the failure of counseling psychology to aggressively capture a realistic portion of the primary prevention turf may lead soon to its demise as a specialty, is worth giving serious consideration.

A similar but more optimistic perspective has been articulated by Huebner and Corazzini (1984), who comfortingly proclaimed that "counseling psychologists need not become clinical psychologists to survive" (p. 609). They suggest that the specialty's survival, indeed its strength, is based on counseling psychologists developing and using strong developmental and preventive skills along with clinical skills. The integration of these two areas of expertise, according to Huebner and Corazzini, is likely to make counseling psychologists valuable and marketable professionals in the future.

CURRENT PERSPECTIVES ON PRIMARY PREVENTION IN COUNSELING PSYCHOLOGY

As we have seen, the preventive influence has been an historic one in the evolution of counseling psychology and professional counseling. We have seen, also, that its actual place in practice has been darkly overshadowed by remedial counseling services. This state of affairs led Zytowski (1985) to title his 1984 Presidential Address to the Division of Counseling Psychology of the American Psychological Association, "Frank, Frank! Where Are You Now that We Need You?" The preventive and social reform origins that Frank Parsons instituted at the beginning of this century are longed for by many counseling psychologists and professional counselors today.

Let us continue in our review of this subject to the recent past, and then to the current scene. In a challenging paper that summarized work of the Division of Counseling Psychology's Professional Affairs Committee between 1974-1976, Ivey (1976) proposed the psychoeducator model as representing the future for counseling psychology. This model built on previous work examining roles for counseling psychologists, notably including that of Jordaan, Myers, Layton, and Morgan (1968), who identified three distinct but complementary roles.

The first of these roles was labeled *remedial* or rehabilitative. Its purpose was to help those who are presently experiencing some form of psychological difficulty. The second role was called *preventive.* Its purpose was said to anticipate, circumvent, and, if possible, to forestall difficulties that could arise later. The third role identified by these authors was called educative or *developmental.* Its goal was to help individuals to plan, obtain, and derive maximum benefit from a range of experiences that would enable them to discover and realize their potential. Interestingly, these three same roles had been described by Hollis and Hollis (1965) in their earlier treatise on guidance services.

A number of different means for helping were identified in 1968, including provision of exploratory experiences, making environmental interventions, and others. The main tool for helping, however, was still identified clearly as *counseling:* a special kind of interchange between a professionally trained counselor and a person who has sought or might benefit from his (sic) services.

The 1976 Ivey contribution expanded on this tripartite role definition for counseling psychologists, but significantly, it reordered the relative importance of the three roles. No longer was remedial activity said to be the main helping role. It was now suggested that the educative/developmental role assume priority, followed by the preventive role, and then by the remedial. And, in like fashion, counseling would no longer rule the day:

> The counseling psychologist engages in all functions of remediation, prevention, and education, but her or his role is no longer primarily counseling—that "special kind of interchange between a professionally trained counselor and a person who has sought or might benefit from his services" (Jordaan et al., 1968). Rather the counseling psychologist now considers counseling only one of a host of skills to educate people for life. Counseling and therapy, important though they may be, are now limited constructs that fail to take into account the broad new functions of the counseling psychologist. (In Whiteley, 1980, p. 197)

Hurst (1976), a member of the subcommittee on skills dissemination of this committee, elaborated on these new functions for the counseling psychologist:

> "Counseling" is but one of many interventions we now have in our professional repertoire. We are now able to talk about training, consultation, media—such as films, videotapes, computer terminals, bio-feedback, and programmed manuals—to mention just a few intervention strategies. It was never intended that "counseling," which is a process, should become an outcome or be perceived as an end in itself. (In Whiteley, 1980, p. 198)

And, finally, this important Division of Counseling Psychology report embraced prevention as a critical function of a psychoeducator. A part of the statement on prevention describes it in this way:

> Prevention, then, includes issues of socio-economic injustice and unequal income distribution, examination of poor school facilities, study of health delivery systems, job development as well as job counseling...in the broadest dimension, the counseling psychologist in the psychoeducator model is interested in developing the health environment of its citizens. This, of course, is not new and simply reflects the ancient statement of Parsons (1894) that counseling must be concerned with institutions and society as well as the individual person. (In Whiteley, 1980, p. 201)

In 1980, a special issue of *The Counseling Psychologist* focused on the future of counseling psychology in the year 2000 (Whiteley, 1980). A variety of commentators underscored the increasing importance that will be placed on environmental and preventive interventions. Ivey's (1980) concept of correcting the "Parsonian error," i.e., to balance a person's

perspective with environmental considerations, gained much favor. Super (1980) hoped that a person-in-situation perspective, where, he said, "we started," would become common-place not only in popularity but, also, in support and time given to it. But Schwebel (1980), perhaps, was a realist who predicted that, despite the importance of prevention and a community-based psychology, here-and-now and future economic conditions will require the increased provision of remedial, clinical services.

Following that 1980 identity piece, *The Counseling Psychologist* in 1984 contained an historical tracing of the profession (Whiteley, 1984). This examination (which is well worth reading for an elaboration of historical development) concluded by issuing five immediate challenges to counseling psychology. Its fifth is of special interest to us:

> A fifth immediate challenge is to regain involvement in the area of prevention. Initiative has shifted to clinical and community psychology for advancing the theoretical and research base of this fundamental role of counseling psychology...The centrality of prevention to the core role of counseling psychology mandates a fundamental reawakening of interest and activity. (p. 89)

What, then, has happened to these projections about the psychoeducator model, to prevention (and, especially, primary prevention), and to correcting the Parsonian error? What have been the practical effects in academic training programs, in positions secured following receipt of the terminal degree, and in actual job functions?

The effects have not been very noticeable. But, once again, this result is consistent with the historical legacy of ambivalence which characterizes the field.

Survey Data on the Current Place of Primary Prevention in Counseling Psychology Practice

Results from recent surveys of counseling psychologists undertaken by Banikiotes (1977, 1980), by Goldschmitt, Tipton, and Wiggins (1981), and by Alcorn and Nicholas (1983), show that contemporary counseling psychologists identify more strongly than those surveyed in the 1960s (e.g., Yamamoto, 1963) and 1970s (e.g., Osipow, 1977; Osipow, Cohen, Jenkins, & Dostal, 1979) with psychotherapy, and psychodiagnostic roles (Watkins, Jr., 1983b). Moreover, the psychotherapy role appears to be

embraced more fully by younger members of the Division of Counseling Psychology, while older members continue to support psychodiagnosis (Goldschmitt et al., 1981; Tanney, 1982).

The relationship between counseling psychology and prevention has been directly surveyed by McNeil and Ingram (1983) through an analysis of training programs and internship sites open to counseling psychology students. They found that only a few students take a course or receive any training in such important preventive areas as program development and evaluation, systems analysis, and in community psychology and prevention research. Their conclusion? "Current curricula and training practices for counseling students do not reflect a strong commitment to, or involvement in, preventive types of approaches" (McNeil & Ingram, 1983, p. 95).

Similarly, when counseling psychology program directors were surveyed (Richardson & Massey, 1986) about students' interest in a variety of training topics, those receiving the lowest ratings were courses in program development and administration, environmental intervention, and rehabilitation counseling. The first two of these would seem directly related to primary prevention. The low interest registered in them is disappointing for the future of primary prevention in counseling psychology.

In terms of employment, Galassi and Moss (1985) also surveyed the counseling psychology program directors. With regard to prevention, they found that fully 17.1% of all 1985 graduates moved into private practice positions located in individual, group psychological, and medical/psychological arrangements. This private practice category constituted the second largest grouping of job placements. Consequently, the researchers wonder about the training implications of this finding, since private practice in the past has been largely a secondary placement source. Clearly, private practice would not constitute a main placement setting for graduates keenly interested in conducting primary prevention activities. These trends in the various surveys cited point to the conclusion that counseling psychologists are defining themselves less by their historic concern for developmental and preventive interventions while identifying increasingly with remedial activities.

To examine this possibility, as well as the broad scope of contemporary counseling psychology, Watkins, Jr., Lopez, Campbell, and Himmell (1986) conducted a survey of Division of Counseling

Psychology members. The comprehensive questionnaire was mailed to 980 randomly selected members of the Division's 2,549 membership. A 73% (716 questionnaires) final sample of usable returns constituted the data pool. A number of interesting findings emerged, which I will highlight.

The dominance of individual psychotherapy as the most frequently performed activity was confirmed. Conversely, structured groups, vocational assessment, and vocational counseling were least frequently done. And in terms of psychotherapy, group therapy was reported to be conducted only 6.9% of all therapy time, while the individual approach commanded fully 67.9% of the total.

Where are the current crop of counseling psychologists working? The second largest setting is private practice, where 22% of this sample (n = 143) finds itself. This percentage, it should be noted, is considerably higher than those revealed in previous surveys of this kind. (See, for example, the survey results reported by Galassi and Moss, 1985, of 17.1%). The largest work setting, however, remains university affiliation (34%), but the departmental locations are of great interest. While 9% of the counseling psychologists are attached to departments of psychology, 20.3% are a part of "other" academic units. These other departments include counselor education (n = 24), counseling (n = 16), counseling psychology (n = 9), and education (n = 8); student counseling centers constituted an additional 118 members, or 17.8%.

These findings about employment settings present an interesting mix. On the one hand, the private practice setting is apparently continuing to attract an ever larger number of practitioners who, presumably, are interested in remedial, clinically-oriented work. On the other hand, the academic arena remains strong, with faculty dispersing themselves across the broad width of what training programs constitute counseling psychology. Obviously, these programs are found as frequently, or more so, in departments of education and counselor education as they are in psychology and counseling psychology.

Participation in primary prevention activities is of special interest, and here more survey results would be greatly welcomed. Yet, given what was reported in this study, we find that over one-third (n = 232, 35.9%) of the sample indicated their involvement with primary prevention activities. This figure is gratifying for those who are primary prevention supporters, especially given the contemporary emphasis being accorded

to remedial functions. However, the researchers found, also, that the amount of weekly time contributed to primary prevention work is relatively low. Sixty-one percent of those engaged in primary prevention activities devoted five or fewer hours per week, and the average number of weekly hours given to these activities was found to be 8.39. This figure amounts to about 18% of an average work week (of 46 hours) being put by these counseling psychologists to primary prevention work. While obviously they are not investing most of their time doing prevention, counseling psychologists are certainly involved, perhaps more so than is commonly assumed.

However, when queried about their professional self-view, the majority of these respondents (19.2%) saw themselves as "clinical practitioners." When asked about which professional designation they most identified with, counseling psychologist, clinical psychologist, or counselor, the order of choice was counseling psychologist (76%), clinical psychologist (15%), and counselor (9%). Yet, when they were asked if they could choose their career over again what would they choose, about 30% said they would select clinical psychology or psychiatry if they could. Thus, while these Division 17 respondents view themselves as counseling psychologists, an appreciable number of them might prefer to be either more clinical or more medical in their designation. These findings confirm that the predilection with things clinical and medical is still robust.

Finally, in terms of this very recent survey, the researchers caution that these findings are applicable to only counseling psychologists who are members of Division 17. One wonders how counseling psychologists who are not members of this Division, as well as professional counselors, would respond to a similar set of questions?

Given this admonition, the results are still of considerable interest. They document again the present importance of clinical and remedial work for counseling psychologists; they show the breadth of affiliation in counseling academic programs for counseling psychology faculty; and they verify the participation of today's counseling psychologist in primary prevention work, albeit not at substantially frequent levels.

WHAT ABOUT PROFESSIONAL COUNSELING?

What this survey, and most others presented in this chapter, does not indicate is the extent to which professional counselors who may not be aligned with the American Psychological Association are involved with primary prevention work. Although counselors are members of other disciplines and professions (e.g., social work, nursing, the ministry), for our purposes the professional counselors we are concerned with constitute the approximately 55,000 members of the American Association for Counseling and Development (AACD).

The specific kind of survey information we need to answer this question is relatively unavailable, despite the comprehensive surveys of counselor education programs conducted by Hollis and Wantz over the last 15 years (e.g., see Wantz, Scherman, & Hollis, 1982). It is clear, however, that the strongest current surges within AACD and professional counseling seem to center around mental health counseling, counselor licensure, third-party payments, private practice, full parity with other mental health professionals, the treatment of special populations in private and community settings, and academic program accreditation. These trends clearly represent movement in the same general direction as that already noted for counseling psychology. That is, professional counseling is pursuing with vigor the domain of remedial, clinical work and it is attempting to take rigorous steps to advance and protect its efforts.

For example, within AACD the fastest-growing Division as well as the largest, is the American Mental Health Counselors Association (AMHCA). The sensational growth of this Division illustrates the interest in mental health counseling services, most of which may be characterized as remedial in focus, that are delivered outside the educational system to a broad range of client populations. This phenomenon is quite at variance with the educational guidance theme that historically dominated the predecessor of AACD, the American Personnel and Guidance Association (APGA).

At the same time, AACD continues to embrace considerable diversity (Herr, 1985). It maintains its traditional commitment to guidance, counseling, and personnel work, and it fully includes qualified masters degree and doctoral degree members. It has markedly increased its advocacy efforts on behalf of its members in areas such as credentialing,

government relations, human rights, international relations, and development of a knowledge base.

Indeed, if AACD intends to become a powerful force helping to shape the direction of professional counseling, as opposed to its historical role of a loose federation of professional interest groups, it must stake out a claim in each of these areas. For, as Mathewson (1962) observed over two decades ago, the real dilemma of guidance and counseling always has been the lack of an adequate framework and technology for delivery, the absence of a coherent system. This deficit continues to hobble professional counseling, although less severely.

Thus, without an effective organizing framework over the years, professional counseling has borrowed from and evolved in relation to counseling psychology. In a real sense, the professional counseling of APGA/AACD has been an egalitarian derivative of the counseling psychology of APA. The theory, techniques, and research that have guided professional counseling over the last 40 years—ever since the publishing of *Counseling and Psychotherapy,* in fact—have been largely drawn from counseling psychology.

As Miller (1986) has observed, with reference to the past 45 years existence of the Association for Counselor Education and Supervision (an AACD division) and to its future, this reliance on counseling psychology could be a problem for prevention. As he put it:

> The current trend to emphasize "Counseling Psychology" and to duplicate the activities of Division 17 of the American Psychological Association (APA) could easily lead to deemphasis on the preventive aspects of guidance... (p. 248)

I worry, along with Aubrey (1983), that the counseling profession has withdrawn from its earlier images rooted in social reform, and that its attachment to clinical approaches has taken it too far afield. As Aubrey stated, with reference to professional counseling:

> In retreating from these social issues, the counseling profession has shifted to a focus on the audiences-victims of social maladies and suitable interventions. This emphasis on the person rather than the social environment was inevitable given the counseling profession's heavy reliance on models derived from psychology....In particular, the choice of counseling as the sole or primary instrument has reinforced as a misdirected emphasis on the person. (p. 81)

Aubrey's prescription is for professional counseling to adopt a future image concentrated on prevention and amelioration rather than

on cures and restoration, thus recapturing its historic call for social reform. Yet, to do so would mean running counter to the prevailing winds within the profession that blow strongly toward remediation.

Perhaps some things are beginning to change. Recent counselor education program training data (Wantz, Scherman, & Hollis, 1982) indicate that 31.6% of preparation training time is devoted to "preventive counseling" emphases, with a lesser 27.7% given to "corrective counseling" (the most time, 40.4% is said to be spent on "developmental counseling" training). While undoubtedly definitional problems galore are involved in arriving at these determinations (e.g., how do preventive and developmental counseling emphases differ? How does "preventive" relate to "primary preventive," which is our main interest?), this finding is encouraging for the future primary preventive practice of students being prepared in today's counselor education programs. The verdict is still out on this one.

Another positive signpost of change, as Aubrey (1983) rightfully observed, is that many counselors are dealing presently with social conditions such as overcrowding, substance abuse, unemployment, crime and violence, unequal wealth distribution, high illiteracy and dropout rates, and a multitude of other social pathogens. As in counseling psychology, though, they are the exception rather than the rule.

PRIMARY PREVENTION IN COUNSELING: RHETORIC OR REALITY?

Following this fairly lengthy historical and research review of the place of primary prevention in counseling psychology and professional counseling, what can we conclude? Is there a promising future, or, perhaps, none at all?

With regard to counseling psychology, the case still seems to be that it is the most broadly-based applied psychology specialty, as Ivey (1979) maintained, with the potential for remaining in the year 2000 "...the closest thing to the general practitioner that the mental health specialties provide" (Osipow, 1980, p. 19). Indeed, Stone's (1986) insightful analysis of perspectives and functions in counseling psychology attests to this breadth.

By tracing the historical development of the specialty, Stone has been able to identify discernable functions in counseling psychology: Guiding (e.g., vocational counseling), healing (e.g., brief therapy), facilitating (e.g., client-centered counseling), modifying (e.g., behavioral counseling), restructuring (e.g., cognitive therapy), developing (e.g., developmental counseling), influencing (e.g., social influence counseling), communicating (e.g., family counseling), and organizing (e.g., community consultation). The result is a comprehensive system of counseling functions that both reinforces and extends previous work in this area (e.g., Osipow, Walsh, & Tosi, 1980, 1984), and it provides a road map for counseling activity to occur across the broad spectrum of human experience.

The survey findings cited in this chapter reinforce, also, the inclusive APA definition of counseling psychology as a specialty (Kirk, 1982). This definition supports working with a wide range of populations, settings, problems, and techniques. As Watkins, Jr., et al. (1986) found in their survey results:

> Contemporary counseling psychologists seem to be a diverse group providing a broad array of services; for example, they offer psychotherapy to the emotionally distressed, provide vocational counseling for clients seeking career assistance, and engage in some measure of psychodiagnostic and *preventive* services. (p. 307) (italics inserted)

As well, the definition of counseling psychology offered by Brown and Lent (1984) in their valuable contribution to the field, the *Handbook of Counseling Psychology*, offers much hope for primary prevention in counseling psychology in the future.

> ...an applied psychological discipline devoted to scientifically generating, applying, and disseminating knowledge on the remediation and prevention of vocational, educational, and personal adjustment difficulties. (p. ix)

This *Handbook*, which contains an entire section on "prevention and community-level interventions," may serve to help refocus deserving (and long-avoided) attention on the significance of primary prevention in counseling psychology.

When probing more deeply into all the studies summarized in this chapter, however, what becomes apparent is that today's counseling psychologists have intensified their involvement and identification with clinically-oriented fare. Individual psychotherapy in private practice appears to be the rising star. The importance of developmental and primary

preventive involvements continues to be expressed. However, their actual practice has not kept pace, despite the evidence that prevention is important: the encouraging participation in primary prevention activities found for Division 17 counseling psychologists (Watkins, Jr., et al., 1986); the survey findings showing the current emphases on preventive and developmental counseling in counselor education training programs (Wantz, Scherman, & Hollis, 1982), and the emphasis given to primary prevention in counseling psychology in the recent *Handbook of Counseling Psychology* (Brown & Lent, 1984).

I am led to conclude that the present-day findings continue to reaffirm the historical conditions surrounding the place of primary prevention in counseling psychology, and in professional counseling, as well. As the title of this chapter suggests, this condition has been—and remains, it appears—one of ambivalence.

Perhaps a kind of rhetorical fascination with primary prevention in the counseling professions has overtaken the original deep commitment to it that was forged by Parsons and others. "Do as I say, not as I do" may be an apt expression to describe the current scene where primary prevention and developmental services are frequently espoused, but less often practiced.

Certainly, this is the view of Hansen (1981), Watkins, Jr. (1983b), and Aubrey (1983), who have each commented forcefully on this situation. Hansen insisted that the rhetoric supporting the place of primary prevention in counseling psychology was unmatched by the reality of counseling psychology practices. While Aubrey allowed that some professional counselors are engaging in social reform, he decried the preoccupation with remediation and pathology. Watkins, Jr., in a similar vein, observed that the image of counseling psychology was contradicted by its central actions. In fact, he went further, by warning:

> If we continue in our current state of duplicity—voicing commitment to the preventative and vocational while engaging increasingly in the remedial—I am afraid that counseling psychology will remain at an impasse. It will neither move forward nor backward; it is likely to become superfluous vis-à-vis other specialties that view psychotherapy and/or psychodiagnostics as vital to their professional identity (e.g., clinical psychology, psychiatric social work, mental health counseling). (p. 474)

Ambivalence. Rhetoric divorced from reality. Duplicity. These strong sentiments would seem to accurately describe the present (and

historical) status of primary prevention in the counseling professions. What shall we do? Can we continue to tolerate this uncomfortable situation? Is it the best we can do?

WHAT CAN BE DONE?

Watkins, Jr., (1983b) indicated that two courses exist, at least for counseling psychology, and that it should decide finally to take one or the other. These courses are (1) To practice what it preaches. Revamp graduate programs and internship sites to include training in prevention (I would modify that to specify primary prevention). Provide more emphasis on vocational and developmental matters in the curricula. Commit to the adoption of the preventive and developmental as being critical to the counseling specialty and acting consistently within that commitment; or (2) To admit that the specialty is increasingly less interested in the vocational, preventive, and developmental while becoming more interested in the remedial. This route would lead to adoption of the psychotherapy and psychodiagnostician roles as basic to counseling and serve to progressively eliminate primary prevention as a goal for practice.

Aubrey's (1983) recommendation for professional counseling sounds resoundingly the same:

> The major concern with the counseling profession at the present time is its lack of focus and attention. One resolve is to establish work with youth and emerging social issues as the major focus of the coming decades. This would be followed by setting priorities for these issues, creation of appropriate intervention strategies, and the getting on with the business of helping people before disaster strikes. After all, this is really how the counseling profession began, and it wasn't a bad beginning! (p. 82)

One might very well be able to predict where I stand on this matter. Although I unequivocally support the importance of individual corrective services when they are needed (and, in fact, I am a purveyor of the same on a limited private practice basis), it is the primary preventive approach that affords the best chances for the counseling professions to be maximally helpful as well as to guarantee their own future well-being. I believe that we need to extract the duplicity from our professional jaws so we may be able to match our rhetoric about primary prevention with real practices. We must affirm primary prevention as a mainstay of counseling psychology and professional counseling and devote training

resources to see that practitioners and researchers engage in its activities more fully.

By so doing, the counseling professions also will be able to define for themselves a clearer identity, one that would be entirely consistent with their origins in social reform and prevention. It is high time for clarity to emerge if these professions are to ever develop beyond their extended adolescent stage and exert the kind of mature leadership required in this complex age.

Happily, the counseling field has produced a number of perspectives and practical approaches that are genuinely reflective of primary prevention. In Chapter 3 will be examined four of these approaches, including an expansion of the psychoeducational one we touched on briefly in this chapter. These are the (1) ecological approaches, (2) outreach and community counseling approach, (3) psychoeducational skill development approach, and (4) health counseling approach. An examination of them should begin to demonstrate how primary prevention and counseling can work effectively together.

ISSUES FOR REFLECTION AND DISCUSSION

1. Vocational guidance, social reform, and mental health and hygiene were three of the foundations for counseling. What are their unique primary prevention aspects?

2. Why was Carl Rogers' *Counseling and Psychotherapy* so important for the counseling field generally and for its primary prevention directions specifically?

3. Regarding the identity of the counseling professions, do you see the identity as "fluid" and positive or do you see it as "confused" and negative? Give some examples to support your position.

4. What did McNeil (1986) mean when he said that counseling psychology's commitment to prevention got lost in the array of its more "valued" activities? What were these other activities? What is your thinking about this issue?

5. Some writers think that counseling psychology will disappear as a psychological specialty due to its reluctance to fully embrace primary prevention. Others are more optimistic, thinking that a greater emphasis on development and prevention will be forthcoming. What are your ideas about this matter?

6. Define and give examples of remedial, developmental, and preventive counseling interventions. How do they relate to primary prevention in counseling?

7. In general, what do the recent studies of counseling psychologists and professional counselors suggest about the place of primary prevention in the counseling professions?

8. Why is it that Frank Parsons is considered so important to the development of counseling? And to the place of primary prevention in it especially?

9. In what ways has the place of primary prevention in counseling been treated with ambivalence? Give two examples.

10. Suppose you had the power to resolve this ambivalence. What would you do? Would your actions serve to advance primary prevention in counseling, or to minimize its place? Give a rationale for your actions.

HIGHLY RECOMMENDED SUPPLEMENTARY READINGS

Aubrey, R. (1983). The odyssey of counseling and images of the future. *Personnel and Guidance Journal, 62,* 78-82.

This article traces important historical developments in the counseling field and examines some future possibilities.

Brown, S., & Lent, R. (Eds.). (1984). *Handbook of counseling psychology.* New York: Wiley.

This invaluable volume organizes the field into scientific and professional issues, vocational psychology, prevention, training, and special issues.

Herr, E. (1985). AACD: An Association committed to unity through diversity. *Journal of Counseling and Development, 63,* 395-404.

This article concisely but comprehensively identifies the major directions and organizations of the American Association for Counseling and Development.

Watkins, Jr., C., Lopez, F., Campbell, V., & Himmel, C. (1986). Contemporary counseling psychology: Results of a national survey. *Journal of Counseling Psychology, 33,* 301-309.

This article conveys recent national data about the training and functioning of counseling psychologists, including information of preventive activities.

Whiteley, J. (1984). Counseling psychology: A historical perspective. *The Counseling Psychologist, 12,* 3-109.

This special issue traces the historical development of counseling psychology, divided into seven periods of time.

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CHAPTER 3

SUPPORTIVE CONCEPTS AND APPROACHES

Although the place of primary prevention in counseling psychology and professional counseling has been characterized by ambivalence, at the end of Chapter 2 some bright spots were noted. Some comfort comes from learning that, when talking of the place of primary prevention in counseling, we do not need to engage in fairy-tales! The situation is far more than having to believe that the moon is made of blue cheese or that elephants really can fly. We do not need to use our imagination to fantasize how things could be *someday*. Indeed, the purpose of this chapter is to describe the existence of real concepts and approaches that presently support primary prevention in counseling.

Supports to be covered in this chapter are contemporary. They are being generated by theoreticians and researchers and used by counseling practitioners now. We do not have to return to 1909 to discover these preventive influences, although we do need to remember that today's counseling, in fact, is built upon the foundations of prevention and social reform that were established then. In this chapter we will be considering some of the current contributions to prevention in counseling, with special attention given to primary preventive influences.

By doing so, we are not seeking to create a new paradigm (Kuhn, 1962) in counseling, such as was the subject of a recent special issue of the *Journal of Counseling and Development* (1985). Rather, we are refocusing on the original paradigm for counseling—prevention—which,

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although it has been diffused and muted over the past 40 years, has exhibited considerable strength through a variety of approaches. It awaits to be rediscovered and articulated.

As you may recall from Chapter 1, the world of primary prevention interventions is divided into two hemispheres: (1) system change and (2) person change. We had said that the system change approach, with its concentration on the elimination of the social evils of this society (e.g., the "isms" of age, race, and sex), holds the most potential for primary prevention and needs to be doggedly pursued. However, we observed, also, that this is a longer-range effort requiring considerably more practical models and methods than are currently available.

On the other hand, the broad range of person change interventions has been the most well-developed to date. Within person change, it is the *competency enhancement* approach that is the most doable by counseling psychologists and professional counselors. Their orientation and training favors training and education, both of which are heavily involved in competency enhancement. Therefore, in this chapter we will closely examine the competency enhancement contribution to primary prevention in counseling.

COMPETENCY ENHANCEMENT CONTRIBUTIONS

The competency enhancement approach is used to instill in humans and in human settings the necessary resources to support successful functioning. This development of competency, whether it be directly within people or in their immediate surroundings, is thought to provide the capabilities to withstand debilitating life stresses. Thus, for example, people can learn effective problem-solving skills and healthier life style habits, thereby increasing their ability to cope with the future demands of life; or microenvironments themselves can be altered to become more competent in their support and challenge of members.

Underlying this people and environment discussion is the first conceptual contribution to primary prevention in counseling that requires elaboration, the ecological perspective. Following it, we will examine the contributions to primary prevention in counseling of outreach and community counseling, psychoeducational skill development, and health counseling.

THE ECOLOGICAL PERSPECTIVE

A cartoon in the "magazine of popular Psychology," APA's own *Psychology Today* (Nov., 1986, p. 16), shows a young child who is being scolded by his mother for (probably) accidently dropping and breaking the cookie jar proclaim, "Get a grip on yourself, Mom! I'm just a child." Such a homely incident economically illustrates the ecological perspective.

The child and his mother are in an ecological relationship, in this case, a tension-filled one. The behavior of each person can be understood accurately only by recognizing that situational reality, and how each person influences the other. The mother is upset because her little boy knocked the cookie jar on the floor and broke it in his no doubt off-limits pursuit of sweets. The child is upset, not only because he failed in his efforts to get cookies, but, also, because his mother is yelling at him. Who knows? He may be upset, also, because the cookie jar was broken. The point is that neither person is independently upset. They have arrived at their emotional state in direct interaction with each other, thus the ecological property of the situation.

In an effort to avoid such uncomfortable confrontations again the mother could be led to learn and use more constructive interaction skills with her young child (a behavioral skills approach), she could begin to place the cookie jar in an unreachable place (an environmental approach), or she could alter her expectations about what a young child can be expected reasonably to do (a cognitive approach). Any or all of these changes might exert a positive effect on the ecological relationship between mother and child.

Again, the message here is that a person's behavior does not occur in a vacuum. It does take place within a situation: in relation to other people or things. For instance, I am now on sabbatical, freed from most of my ordinary work responsibilities. Instead of commuting in city traffic to my University office and dealing with a host of administrative and people problems (and even pleasures) each work day, I now retreat a few short steps down the hall to my home office and face a blank computer screen on a daily basis. Here, I work in relative solitude, writing this book using a computer technology for the first time. For now, my life is greatly different, not because I have independently changed, but because my work situation is vastly different. Its alteration affects me, I am

pleased to confess, happily. Therefore, to understand me these days one must appreciate my life situation (in this case, my work) and how it is affecting me.

Most of applied psychological practice and counseling, however, has ignored the ecological approach. Think about it by considering for a moment the mother in the cartoon I previously described. For instance, if she goes to her counselor or psychotherapist later in the day and expresses her anger and frustration there, she would most likely be led to an intrapersonal exploration of some sort. "Elaborate on your feelings." "What leads you to feel this way, do you suppose?" "Do you recall being treated that way when you were a child?" "How do you feel as a mother?" "Do you become as upset by other things that happen?" "What's really going on?"

Now, all of these questions and leads may be appropriate in their own way. But, for the most part, they avoid the nub of the matter, which is to identify what can be done to improve the mother-child situation so that future conflicts can be prevented.

The ecological perspective is rooted in the work of Lewin (e.g., 1936), who was mentioned in Chapter 1. He presented the concept that behavior is a function of persons interacting with their environment which, as we have seen, is quite similar to the Parsonian notion expressed 25 years or so prior. Murray (1938) added the concept of "environmental press" to refer to the influence of conditions and settings on human behavior. Pace and Stern (1958), Stern (1970), and Astin (1968, 1984) were among those who applied this person by environment concept to the empirical measurement of the effects of college and university environments on students.

Rudolf Moos and his associates (e.g., Insel & Moos, 1974; Moos, 1979) have adapted this basic orientation to a variety of settings, as we also saw in Chapter 1. They contributed a set of sophisticated social climate measures and a somewhat less defined social setting change procedure. This work has advanced the use of an ecological perspective by a wide range of helping professionals because it provided not only a coherent framework for conceptualizing social ecology, but, also, it made available the means for putting it to practical use.

Counseling psychologists have been using the social ecology methodology of Moos in several ways. A main application has been in

organizational consultation. For instance, a colleague (Lynn Rapin) frequently is called upon by health care concerns (hospitals, home care nursing units) and mental health centers to help them to assess and redefine elements of their operation such that organizational functioning and patient care are improved. In a current case, she used the *Work Environment Scale* (Insel & Moos, 1974) to identify any discrepancies existing between managers and employees of a community mental health center about what each group perceived to be ideal, as compared to actual, working conditions. These discrepancies were then fed back in group form by the consultant as the initial phase in facilitating their decision-making to determine if organizational change was warranted and, if so, how it was to be accomplished. Because the changes decided on involved considerable redefinition of positions, reporting levels and relationships, the consultation has been particularly emotional in tone. The goal, however, is to create an organization that is structured more effectively, uses the talents of its personnel more fully, and better meets the needs of clients.

As Blocher and Biggs (1983) pointed out, the rudiments for this sort of ecological consultation were present in the counseling literature long before the advent of the community mental health movement or the full emergence of either social ecology or primary prevention. For example, they quote from the classic book of E.G. Williamson, *How to Counsel Students* (1939):

> All individuals are subject to psychological and social stresses and strains which may produce erratic or unusual behavior, sometimes called abnormal. Sometimes an individual will be alarmed or even terrified simply because he differs from his associates in his reaction to life situations...Frequently, the counselor can assist in changing the external conditions which may have caused or aggravated the student's disturbance...The counselor must also have acquired some understanding and appreciation of the possible effects upon the student of social, educational and occupational situations...in the future. (In Blocher & Biggs, pp. 13-14)

According to Blocher and Biggs (1983), counselors have long been busy working in the natural settings of school, family, and work place, helping people to cope more adequately with the practical problems of daily living. Perhaps this heritage helps to explain why the ecological perspective holds much attraction to counselors.

Campus Ecology

Higher education counselors have made considerable use of the ecological perspective in the area of campus ecology. This approach, defined originally by Banning and Kaiser (1974) and adapted in other efforts (e.g., Banning 1978; Conyne, 1975; Conyne & Clack, 1981; Daher, Corazzini, & McKinnon, 1977) concerns itself with creating campus environments that appropriately challenge and support students. The ecological perspective is used for identifying the positive and negative ways in which students interact with aspects of their campus environment. Thus, the focus of campus ecology is said to be on the transactions occurring between targeted groups of students with selected campus environmental elements. The goal is to produce a more optimal "person-environment fit" between students and the campus environment.

An action methodology has been developed to complement the campus ecology approach. Called the "ecosystem design model" (WICHE, 1972 and further defined by Banning & Kaiser, 1974, and by Aulepp & Delworth, 1976), its seven-steps provide a concrete process for intentionally designing campus environments that will optimally benefit students' educational and personal development.

A basic underpinning for this ecosystem model is the still radical notion that students are not entirely the cause of all their problems and that they should not automatically become the change target. Rather, it holds that environments themselves contribute to either student health or dysfunctions and that they should be included in assessment and change efforts. Thus, we can think in terms of environments that are unhealthy or healthy, just as we can think of healthy and unhealthy students.

Several examples of healthy and unhealthy environments come to mind. Let us first of all address the unhealthy campus environments. Consider the academic department which prides itself on aggressively flunking out "unworthy" students and creates the kind of severely competitive and non-supportive academic environment that allows this to frequently occur. Or, think of the University that reaches out to admit minority students from the inner city in an effort to broaden their educational opportunity (and, perhaps, to bolster enrollments, too) but which fails to provide the academic support services that are so necessary to help these often underprepared students to survive in the demanding institution. Consider the urban institution that draws heavily from the immediate environs yet provides inadequate parking facilities for its com-

muting students. What of the institution that has developed a policy to prevent sexual harassment but which has established no procedures for its implementation? Or, think of a college which, during the severe budget reduction times of the early 1980s, decided to save funds through eliminating its student affairs division with the consequence that current students are now left without extra-classroom personal development programs and services and limited advocacy within the institution.

We also can envision examples of a healthy campus environment. How about a college whose attendance at intercollegiate sporting events and in student life in general is high? Or, consider the University campus which is kept spotlessly clean. Think of a place where important committees seek and contain representation from major constituency groups on campus. Consider the institution which has provided accessible buildings for its handicapped population and has made available affordable day care services for its many adult women returning to school. Or, as a final example of a healthy environment, think of a setting where faculty and staff actively seek to interact with students as a matter of course.

Student development in our educational institutions simply does just not occur. As Blocher (1974) has observed:

> ...developmental processes do not just happen but rather must be purposefully triggered and carefully nurtured by the environment if full potential for growth is to be reached. (p. 361)

For Blocher, this triggering and nurturing by the educational environment is based, also, on an ecological model. In examining the elementary school classroom environment, for instance, he finds that three subsystems are involved. The first is the opportunity structure of the classroom, which he suggests should be broad-band in nature. That is, a full range of novel, intense, complex, and ambiguous opportunities need to be made consistently available for student involvement if students are to be stimulated and challenged to learn. The second subsystem that Blocher indicated as being necessary is that of support. Teacher-to-student as well as student-to-student relationships are critical for enabling students to be properly assisted to take advantage of the opportunities provided. Third, he suggested that a classroom subsystem of rewards is important for fairly guaranteeing that effort expended in the learning endeavor by students will be connected properly to progress and self esteem.

The primary preventive contribution of the campus ecology approach is connected directly to its focus on environmental change strategies (Conyne & Clack, 1981; Forgays, 1978; Krasner, 1980) to benefit students. In fact, step four of the ecosystem design seven-step model I referred to earlier demands that environments be fitted to students. Doing so can lead to improved policies, new programs and services, cleaner buildings and grounds, training programs for personnel who work with students, and other innovations of this kind which can promote student health and prevent student difficulties. This approach stands in marked contrast to the reactive and remedial approaches that have dominated both educational and mental health practice. As I wrote a decade ago (Conyne, 1977), in a fairly impassioned plea for reorienting the directions of counselor education from an intrapersonal to an ecological focus:

> In all functions, ecological counselor education would try to change environments, and thereby people. This intent represents a major reversal of how most counselors and helping professionals function. Acceptance of this contradiction and its implementation in practice could revolutionalize the profession and its place in education and the helping services. (p. 312)

Because of its environmental change focus, campus ecology fits within the microsocial approach to competency enhancement. Its principal uses have been within organizations and groups of a college or university. For example, it has been applied frequently in residence halls, classrooms, and academic departments. However, it has been employed occasionally within an entire campus (e.g., Conyne, 1978), addressing such issues as interracial climate, campus safety, social climate, and academic policies. This broader application is closer to the system-level intervention in primary prevention.

Whatever the target, however, campus ecology remains an approach to campus primary prevention that holds considerable unfulfilled promise. Huebner and Corazzini (1984), in their status report on environmental assessment and intervention in counseling psychology, drew the following conclusion with regard to the practice of counseling centers in higher education:

> Counseling centers similarly do only limited work with the environment-as-client partly because staff lack relevant skills. Efforts are focused on one-to-one therapy, programming, and consultation. For most counseling centers, consultation and program development have remained the vanguard of the preventive-developmental focus; the more nontraditional orientation of physical or organizational system change remains an unrealized dream or an ignored domain. (p. 612)

OUTREACH AND COMMUNITY COUNSELING

Outreach and community counseling represent two forms of innovative counseling practice that promote the concept of counselors widening their involvement and influence well beyond the counseling office. In fact, at the base of both approaches is a dedication to primary prevention and to the use by professional counselors and psychologists of a multidimensional set of interventions to positively affect people and settings. Let us first take a look at outreach in counseling.

Outreach in Counseling

Drum and Figler (1973), in writing about the college counselor, were among the first to envision the counselor to practice what they termed "growth and prevention." They also developed a seven dimensional model to show how growth and prevention could be accomplished on the college campus. During the 1970s and 80s a number of college and university counseling centers have been putting aspects of this orientation into practice through a gamut of outreach activities, such as paraprofessional leadership programs, consultation about campus environmental change, staff and faculty development training, and computer-assisted career counseling. At the same time, most counseling centers have persisted in providing only remedial, clinical services.

The growth and prevention model of Drum and Figler maintains that an effective counseling service will

> ...shed its primarily *remedial* role and will be engaged in the *prevention* of student problems. By identifying the forces which generate students' problems and by building programs to neutralize these forces, the counselor can diminish much of his (sic) remedial and corrective work. *Prevention* and *growth* are twin dimensions of a single model which emphasizes providing counseling services for all members of a student population. Not only does the counselor work to eliminate the factors which are responsible for a student's problems; he (sic) also builds programs which capitalize on the student's desire for growth, his abilities and positive forces in the educational environment. (p. 19)

While these authors never intended that a growth and prevention model would replace corrective counseling, they did think that its activities could greatly improve the overall effect that professional counselors and psychologists could have on students in the campus community. In their view, the practitioner's impact could be multiplied many times over through an emphasis on growth and prevention instead of on

remediation. A brief examination of Drum and Figler's seven dimension model will help to better understand their claim.

Each of the seven dimensions of this growth and prevention model are arranged along a continuum ranging from what they term the "direct service model" (remedial) on the left side toward greater evidence of "growth and prevention" on the right side. The seven dimensions, and the continuum end points for each are (1) *problem awareness,* ranging from an acute problem to preawareness of problems; (2) *intervention targets,* ranging from working with an individual client to the educational institution; (3) *setting,* ranging from the counselor's office to natural environments; (4) *directness of service,* ranging from the helping interview to the indirect involvement of an environmental change agent; (5) *number of helpers,* ranging from the professional counselor only to combinations of naturalistic counselors; (6) *counseling methods,* ranging from using the individual method to a broad educational one; and (7) *duration of counseling,* ranging from a single interview to providing an extended sequence of counseling opportunities.

As you can see, adoption of the growth and prevention end points of these dimensions (that is, those on the right side in each case) would place the counseling psychologist or professional counselor in an *outreach* mode, actively involved with students and the campus environment in a variety of intentional ways. By becoming involved in these extensive ways the counseling practitioner is able to exert a greater impact on the campus, helping it to become in Iscoe's (1974) image, a more fully "competent community."

Community Counseling

Attention to the strengthening of communities fuels community counseling. As Lawton (1970) observed in describing life space counseling:

> Where the counselor's skills are really needed is in the life space of people who don't go to offices and who stay isolated where their problems really exist: in the homes, in the factories, in the ghettos, in the bars, the subways, the streets, the crash pads, the communes, the cafeterias, the toilets, and even the classrooms. (p. 663)

Obviously, no longer are we in 1970, when Lawton told us where he thought counselors should locate themselves. But now in the latter half of the 1980s, his suggestion is at least as apt. The gigantic social problems

that face us—drugs abuse, illiteracy, racism, the homeless, the unemployed, sexually transmitted diseases, broken families, numbing poverty, teen-age suicide, violence in the streets, the threat of nuclear holocaust, the thousands of sad and lonely people who live among us—how can professional counselors and counseling psychologists get involved more potently to make a positive difference?

Following the path cut by community psychology (e.g., Heller, Price, Reinharz, Riger, & Wandersman, 1984; Rappaport, 1977), and building on the preventive, social reform beginnings of counseling itself, community counseling (e.g., Goodyear, 1976; Lewis & Lewis, 1977, 1983) has emerged to provide direction for counselors who seek to lessen the kinds of social problems that threaten our society. Further, this approach shares much with that articulated by Blocher and Biggs (1983), who outlined how counseling psychologists can become productively involved in community settings.

As Lewis and Lewis (1977, 1983) conceptualized it, community counseling represents an innovative, multifaceted human services approach for strengthening individuals and their community. A guiding tenet for community counseling is that prevention is more efficient than remediation. According to Lewis and Lewis, "primary prevention provides the most important underpinning to the work of the community counselor" (p. 5). Primary prevention supports the efforts of community counselors to develop proactive approaches that reach healthy persons and their communities. By intervening in this way, community counselors can help community members to live more effectively and, thereby, to prevent the problems they might otherwise frequently encounter.

The community counseling model developed by Lewis and Lewis (1983) includes four fundamental facets that are described in some detail, because they provide a good organizing framework for understanding how counseling practitioners can involve themselves at the community level. These four facets are as follows:

1. *Direct community services.* Community education programs providing direct experiences, available to the population as a whole. (*Community education*).

2. *Indirect community services.* Community organizing efforts attempting to make the entire community more responsive to the needs of its members. (*Community organization*).

3. *Direct client services.* Client counseling programs providing special experiences to individuals or groups needing assistance. (*Client counseling*).

4. *Indirect client services.* Client advocacy programs intervening actively in the environments of specific individuals or groups, allowing their special needs to be met. (*Client advocacy*). (pp. 13-14)

Community counselors, therefore, involve themselves as preventive agents by providing direct and indirect services to the community at large as well as to designated individuals and groups. As previously indicated, the major types of services they offer are community education, client counseling, community organization, and client advocacy. A few words of description about each of these service types will assist in developing a better understanding of them.

Community education services present knowledge and skills to certain organizations or to the community-at-large in any number of educational formats. For example, Lewis and Lewis (1983) cited a number of consultation and education activities that have been provided by one human services center. These topics include drug abuse education, growing old gracefully, on the road to good mental health, child abuse, jogging for better mental health, and communication skills.

Community organization services are conducted to improve the environment of community members, often through community-based planning and community change. According to Lewis and Lewis, mobilizing community members to work together to plan for meeting their own needs, or advocating on their behalf to get seemingly impossible things accomplished are two important functions that community counselors can perform. Youth services, tenant rights, child abuse prevention, and services to seniors are just a few examples of some outcomes that can emerge from these kinds of community organization involvements. One especially important resource that community counselors can provide in these efforts would be to put their human relations skills at the disposal of people in the community so that members can more effectively carry out community organization or change activities themselves.

Client counseling services, as Lewis and Lewis conceive them, should be proactively delivered and they should be readily accessible. That is, these services to individuals and groups should address whole persons in relation to their environments, and these services should be made available in all kinds of settings so they may be taken advantage of easily. For instance, proactive counseling can be offered in the form of time-limited educational interventions to people currently progressing through a high-risk situation. Lewis and Lewis described "minicourses" of three to six weeks duration for such groups as widows and widowers, the newly separated, the recently unemployed, and people preparing for retirement. A central thesis in proactive counseling is that the community counselor is as concerned with environmental forces surrounding an individual or group as with the person or group itself. The attempt is to facilitate whole person and environment change.

Client advocacy is used by community counselors to stimulate environmental change to benefit individuals or groups having special needs. The community counselor works with such individuals, perhaps the physically or mentally disabled, to help them to strengthen their cause. Sometimes, as Lewis and Lewis indicated, this may happen through taking direct political action on behalf of a wronged party or group, and still other times it can occur through the development of a "helping network" of all resource persons and agencies available to provide personal assistance when required.

As these authors have stated, the focus of community counseling is on preventing conditions and behaviors that clients find dysfunctional. This application of counseling psychology to community settings provides an important conceptual framework and practical means for counseling practitioners to use primary prevention in the real world where the masses of people are living their lives.

PSYCHOEDUCATIONAL SKILL DEVELOPMENT

One of the clearest illustrations of primary prevention in professional counseling and counseling psychology comes from the broad area of skill development. Helping individuals to develop skills they will need for effective future functioning falls directly under the competency enhancement approach to primary prevention that we are considering.

Much of the historical work in skill development has arisen from a social skills deficit model (Danish, Galambos, & Laquatra, 1983; Stone, 1980). That is, skill development would be undertaken with an individual who was assessed to be currently lacking in that very skill. An example is found in the terribly shy person whose counselor helps him/her to correct the social skills in which he/she is deficient. Presumably, the proper learning and use of these new social skills will supply the correction necessary, thus enabling the client to behave more confidently with others in the future. Basically, the foregoing represents the application of skills correction rather than skills development. It explicates the remedial, medical-disease model of deficiency—diagnosis—prescription —therapy—cure.

In primary prevention, however, we are interested in reaching people before they are entrenched in behavioral or other problems. Skill development, therefore, involves the application of educational and training procedures to build into the existing resource repertoire of individuals the range of skills that will allow them to function deficit-free later. This general approach to skills development is commonly referred to as "psychoeducation." As an educational approach, psychoeducation rejects the remedial, medical-disease model mentioned above by endorsing this series of generic steps: dissatisfaction (or ambition)—goal setting—skill teaching—satisfaction or goal achievement (Authier, Gustafson, Guerney, & Kasdorf, 1975; Ivey, 1976). See Chapter 2, also, for a previous discussion of psychoeducation.

The psychoeducational approach to skill development holds much potential for counseling practitioners and others who are interested in designing and delivering effective primary prevention programs that contain a skills foundation. As we have noted, most work has been in the area of skills correction. While more research and experimentation is required before skills development can be applied broadly and confidently for primary preventive purposes, considerable advancement has occurred recently, such that Barrow (1986) could state about the use of cognitive development theories in the student development field:

> They can be useful whether the program goals are remedial (for example, assisting a student with acute depression), preventive (helping academically at risk students learn skills for managing test anxiety), or developmental (fostering independent decision making) and whether the intervention mode is individual counseling, group counseling, or outreach educational workshops. (p. ix)

Cognitive-Behavioral Skill Development

The psychoeducational skills development approaches available for use are many. Perhaps the hottest area of exploration presently, however, is the cognitive-behavioral approach (e.g., Barrow, 1986; Meichenbaum, 1979; Stone, 1980). In this approach, both the thought processes that people engage in, as well as their behaviors, are considered in designing and delivering interventions. Thus a rapprochement of two formerly competing systems, the cognitive and the behavioral, has taken place to produce a stimulating set of interventions.

Many of these cognitive-behavioral interventions can be used preventively, as Barrow (1986) has indicated. Among others, they include skills development in *cognitive restructuring* (e.g., Goldfried & Davison, 1976), so that individuals can learn how to reorder faulty thinking; in *coping skills* (e.g., Meichenbaum, 1977), so that people can learn skills and coping mechanisms for handling difficult future situations; and in *problem solving* (e.g., D'Zurilla & Goldfried, 1971), so that people can learn how to resolve future problems they may face through use of a systematic model involving such steps as problem definition, generating alternatives, and decision making.

An illustration of a cognitive-behavioral preventive approach may assist in understanding how it is generally put to use. Let us take a look, then, at a skill development module presented by Barrow (1986) on developing self-confidence. He described a structured group experience, offered in four to five sessions or in a day-long workshop, in developing self-confidence. It is intended primarily for those college students who are already experiencing some level of difficulty in this area. I believe this approach exemplifies how many cognitive-behavioral methods can be employed, also, with the intention to prevent currently unaffected students from later experiencing similar problems. I will summarize the main elements of what takes place in this structured group experience that are used to develop the targeted skills of increased self-awareness, methods for combatting mental distortions, communicating effectively, and behaving assertively.

First, students are asked to write down situations that threaten their self-confidence. This material then provides the basis for discussions between pairs or in sub-groups.

The group counselor then presents a framework for understanding self-confidence. The students are asked to examine their perceived (actual) and their idealized versions of their physical, intellectual, social, and emotional selves.

Participants are asked to think about how their perceived and idealized selves can be made more congruent. The counselor then outlines the merits of taking calculated risks (i.e., those with a high probability of reaching success) as an important way to increase self-confidence. The skills of the program are then presented as those which can be used to improve the success rate of these calculated risks. The remainder of the structured group experience contains skill development modules in the areas of communication skills, enhanced assertiveness, and combatting mental distortions.

These modules include both cognitive inputs and discussion, as well as behavioral skill training and practice. For instance, the practice aspect of the module on active listening skills involves the participants in the following activities (Barrow, 1986):

> Half of the group members are instructed to be listeners and are secretly told to avoid communicating that they are listening. The other half are told to talk about a topic of interest. Pairs are then formed, containing one speaker and one listener, and a five-minute conversation is held. The feelings and observations of the speakers are then discussed in the group....Participants gain a clearer conception of the role of such nonverbal cues as eye contact, postural orientation, gestures, facial expressions, and head nods. (p. 306)

At the conclusion of this structured group experience on developing self-confidence, participants are asked to identify to the group a "calculated risk" they feel ready to take as an outcome of the training program. Finally, in order to optimally promote the transferability of any skills learned, the group members are assisted to operationalize the next steps they plan to take in developing self-confidence through the use of a planning exercise.

In such a manner as just described, a host of cognitive-behavioral and other psychoeducational approaches can be delivered to groups of individuals who, while being presently free from a disturbance, may be particularly susceptible to experiencing it at some point in the near future. The Life Skills Training (LST) program (Botvin, 1983), a comprehensive intervention for the prevention of tobacco, alcohol, and drug abuse, for instance, holds the potential for teaching adolescents the personal and social skills thought necessary to prevent psychological

disorders, teen-age pregnancy, truancy, and delinquency (Botvin & Dusenburg, in press). While some counseling practitioners are applying this kind of primary preventive approach now, the opportunity for more extensive use is abundant.

Deliberate Psychological Education. Also referred to as developmental education, this model, developed by Sprinthall and Mosher (1970), conceptualizes the professional counselor or counseling psychologist as a psychological educator. It is closely related to the cognitive-behavioral model we just explored.

The psychological educator seeks to advance the cognitive development of learners so that they are better able to master life situations. Frequently, deliberate psychological education (DPE) is attempted through offering classes or workshops in the schools on topics such as interpersonal relationships; identity development; intellectual, ethical, and moral development; racism and sexism; and health improvement. The topics are selected for their apparent practical relevance as well as for their potential for promoting cognitive development in the participants.

One key ingredient of DPE is called higher stage modeling, or n + 1. In this strategy, the intention is that any intervention be delivered at a cognitive level that is slightly higher than that of most of the participants in terms of complexity, ambiguity, or abstraction. Thus, the modal level of cognitive development of the group (or "n"), is addressed at a slightly more challenging level (or "n + 1"). The premise is that by challenging, but not excessively so, the learners can be led to advance in cognitive development at an ideal rate. Doing so thus increases the learners' capacity for successfully thinking about and handling real-life situations.

As contrasted with most cognitive-behavioral approaches (which, as we observed, hold much preventive potential), the deliberate psychological education strategy is intended for developmental and preventive use. Evaluation of DPEs effectiveness, especially with regard to advancing cognitive growth, is being demonstrated in a variety of studies conducted at various levels of schooling. See Mosher (1979) for one review of these studies.

Helping Skills

The "helping skills" collection of approaches is predicated on training helpees to become effective developmental and preventive agents. As

Egan and Cowan (1979) have written, the teaching of helping skills represents "upstream" helping rather than "downstream" helping as *helpers use these skills to promote health rather than to remove illness.*

Training programs in helping skills have been used widely with professionals, pre-professionals (e.g., students in professional counseling programs), and para-professionals (e.g., interested lay people) to give them the concrete helping tools they need for assisting others. A number of helping skills models exist and counselors have been drawing from them for several years.

Regardless of the particular model, however, helping skills training tend to include most of the following (Danish, 1977):

> (1) the skill is defined in behavioral terms; (2) the rationale for the skill is presented and discussed; (3) a skill attainment criterion is presented; (4) a model of effective and ineffective skills is presented; (5) the skills are practiced under intense supervision; (6) outside practice emphasizing continued behavioral rehearsal is assigned; and (7) during the subsequent session an evaluation of skill levels is conducted using behavioral checklists and other evaluation tools. (In Danish, Galambos, & Laquatra, 1983, p. 57)

In general, I think the models available for use can be organized into those that primarily address the development of individual and interpersonal skills and those (fewer in number and less systematic) that focus on developing skills for working with groups, organizations and systems. I will briefly summarize some examples of both approaches below.

A Summary of Individual and Interpersonal Helping Skills Models. Carkhuff (e.g., 1969), Danish, D'Augelli, and Hauer (1980), Egan (e.g., 1986), Gazda (e.g., 1982), Johnson (1972), Ivey (e.g., 1980), and Kagan (e.g., 1980b) are among those who have contributed individual and interpersonal helping skills models to the counseling and human services fields. These models all present procedures, the specificity of which vary, for individual and interpersonal skill development. For the sake of brevity alone, the models of Carkhuff, Egan, and Ivey are highlighted in the following paragraphs.

Carkhuff's (1969) *"human relations training model"* is meant to concretize the basic Rogerian conditions of helping in ways that allow for the efficient and effective training of lay people as well as professionals. This model contains two main phases. In the first, or "inward" phase, the helpee learns the basic skills of empathy, respect, and concreteness.

In the second phase of action, the helpee learns the more advanced skills of genuineness and self-disclosure, confrontation, and immediacy.

Egan has presented a number of useful models that address different aspects of helping skills training. His most recent edition of the *"skilled helper"* model (1986) continues the systematic approach to effective helping while broadening it to include greater emphasis on cognitive and behavioral variables. In Egan's 1986 writings he said his extended helping skills model is actually a problem-management model. Its core still is the systematic training focus on three phases of the helping process: (1) identifying and clarifying problem situations and unused opportunities; (2) goal setting, or developing a more desirable scenario; and (3) action, or moving toward the preferred scenario.

Ivey's (1980) *microcounseling* approach offers a sophisticated model for training in helping skills. It is linked closely to the process of counseling and psychotherapy. Basically, specific skill components that are thought to be vital to the counseling process have been isolated. These components, such as attending behavior, minimal encourages to talk, and reflection and summarization of feeling, are presented to counseling and other helping trainees through explanation, videotape modeling, role-playing, and feedback. As in the other models, the trainees then use these helping skills to benefit their work with others.

Group, Organizational, and Systems Models. Helping skills models that give specific attention to environmental properties and processes that are present in groups, organizations, and systems are fewer in number and more complex in structure than the previous group of individual and interpersonal models we just examined. However, notable models have been developed by Danish and his associates (1983, 1984) and by Egan (1985) and Egan and Cowan (1979). These helping skills approaches seek to assist helpees to become capable intervenors in human systems. Each approach presents fairly well defined conceptions of how to become involved in this larger way, but the specific involvement procedures that characterize the individual and interpersonal approaches are yet to evolve.

The Danish and associates model of *"life development intervention"* seeks to develop personal competence in individuals, that is, their abilities to do life planning, to be self-reliant, and to seek the resources of others in coping. These goals are reached through training in the life development skills of goal assessment, knowledge acquisition,

decision-making, risk assessment, creating social support, and planning. Helpers use these skills when working preventively with groups of people who are experiencing the initial phases of a difficult life transition, such as impending parenthood or retirement. Using the life development intervention model in this way can make it have environmental influences of importance in people's lives.

In 1979, Egan and Cowan developed an innovative *"people in systems"* helping skills model which they intended for the broad range of helpers in human services and education. This model showed the importance of helpers learning not only personal and interpersonal skills but, also, skills that would enable them to function effectively in human systems. They arranged the set of working knowledge and skills needed for this quest into (1) physical development, (2) intellectual development, (3) self-management, (4) values clarification, (5) interpersonal, (6) small group, and (7) systems involvement.

Egan's (1985) book on *change agent skills* in the helping and human services extends the people in systems helping model by focusing on systems involvement skills. While this presentation is more conceptual than procedural, it contributes by illustrating clearly the kinds of working knowledge and skills that helpers need to master in order to be helpful in systems such as the workplace, peer group, classroom, and family. Egan organizes this information into three broad parts, which he terms (1) the performance system itself (e.g., the mission, goals, and program of an organization); (2) the people in the performance system (e.g., their roles and responsibilities, their relationships, and communication); and (3) the pervasive variables that affect the system (e.g., the reward system, politics, and the external environment).

A brief illustration of how system-level helping skills may be used could be of interest. I have developed (Conyne, 1983) a model for conducting student organization development on college campuses that makes use of these skills. The model holds that members (and particularly leaders) of student organizations can be taught system-level skills to better enable them to manage their organizations more effectively. Further, my belief, which is expressed in this model, is that the proper use of these skills can serve to prevent the floundering and all-too-frequent demise of many of these organizations.

Based on these premises, the student organization development model presents skills that both members and leaders can learn to pro-

mote the central organization functions of cohesion, organization, resourcefulness, and energy. Note that the first letters of these functions form the acronym, CORE, which is the shorthand name of the model. I have developed a related CORE checklist, also, which is used to assess the presence of these skills in organizational members and, in turn, as expressed in the organization itself. Assessment results obtained through use of this checklist can then be drawn from to guide the skill development process.

Skill development training in the CORE conditions of the model generally emphasize: (1) Cohesion skills related to team building and process consultation; (2) Organization skills supporting goal setting, program planning, and evaluation; (3) Resourcefulness skills addressing working knowledge of student organizations and the campus, and the development of personal and interpersonal skills; and (4) Energy skills fostering attitudinal development in positive motivation, independence, and cooperation. A manual for teaching both paraprofessionals and organization members these system skills has been developed (Fabe & Conyne, 1982) to guide this activity.

As helping skills models are broadened to address not only personal and interpersonal development but also the environments in which people live and work, they increase their potential for primary prevention. The availability of these systems-oriented helping models in the counseling literature serves to encourage such activity even though the models themselves are at a relatively early stage of development.

HEALTH COUNSELING

The last area we will consider in this chapter as being representative of how primary prevention is now a part of counseling is that of health counseling (e.g., Thoresen & Eagleston, 1984, 1985). Other approaches are associated with this general movement, as well, including health psychology (e.g., Meyerowitz, Burish, & Wallston, 1986; Stone, Cohen, Adler, & Associates, 1979), mental health promotion (e.g., DHEW, 1979; Zins, Wagner, & Maher, 1985), holistic health (e.g., Gross, 1980; Pelletier, 1979), and wellness (e.g., Ryan & Travis, 1981; *Wellness Letter,* UC-Berkeley, 1986a,b).

In general, what all of these health approaches are concerned with is helping people to take control of their lives so as to produce a high level of health through the daily practice of healthy lifestyles. Moreover, they are all based on viewing the human as an integrated system of the mind, body, and spirit. This view recognizes that the historical separation of mind, body, and spirit into independently treated domains disavows the important ways in which all parts influence each other.

The need for promoting health in the populace through health counseling and other similar approaches is becoming crucially obvious. In a major five-year study just completed at the Carter Center of Emory University (*Wellness Letter,* UC-Berkeley, 1986a), 14 primary causes of illness and premature death (that is, before age 65) were identified. In sum, these 14 areas, which include infectious disease, infant mortality, drug abuse, cardiovascular disease, and cancer, were found to account for 85% of all personal health-care costs and 80% of the deaths in this country. The kicker, for primary prevention advocates, is that... "approximately two thirds of these deaths under age 65 are potentionally preventable" (p. 1). The conclusion drawn from the study is that primary preventive approaches can be used to make us a healthier nation. We are not dependent completely upon medical breakthroughs for this goal to be achieved.

This study also provides guidance for primary preventive activities through the identification of modifiable risk factors that significantly affect each of the 14 health problems. The six risk factors most often cited were tobacco use, alcohol use, injuries, unintended pregnancy, lack of preventive service received, and improper nutrition.

Of these six risk factors, tobacco and alcohol registered the highest risks. For instance, tobacco use is implicated as the single leading cause of death in America—some 1,000 deaths each *day,* or about 365,000 deaths per year. And, according to the latest figure (UC-Berkeley, 1986b), alcohol use is not far behind. It causes or is associated with 200,000 deaths every year in the United States, including diseases such as cirrhosis of the liver, traumatic events, such as automobile crashes, and thousands of other accidents.

As Thoresen and Eagleston (1985) observe, personal health is affected strongly by "good" habits—including adequate exercise, sufficient sleep, and nutritious eating—and by "bad" habits—such as

cigarette smoking, excessive alcohol consumption, and insufficient relaxation. To graphically illustrate this position, consider the results of the following study (Belloc & Breslow, 1972) and its follow-up (Breslow & Enstrom, 1980). A representative probability sample of 6,928 adults was studied for five and one-half years in California to determine the relationship between health habits and physical health. Those adults who engaged in most or all of the following healthy behaviors were found to be in substantially better health than those who practiced none or just a few of them: ate breakfast almost every day; rarely or never ate between meals; slept 7-8 hours daily; maintained normal weight adjusted for height, age, and sex; never smoked cigarettes; avoided or used alcohol moderately; and had regular physical activity. Health counseling and the related approaches mentioned in this section can provide professional counselors and counseling psychologists with a basic framework to draw from in promoting healthy behaviors such as those previously listed.

Two strategies would seem to hold particular promise for health counseling of a primary preventive nature. These are employing the expanded cognitive social learning model described by Thoresen and Eagleston (1984, 1985), and providing consultation and training in counseling skills to health care providers, as described by Kagan (1980a). I will summarize each of these health counseling strategies.

Thoresen and Eagleston suggested that an *expansion of the cognitive social learning model* of Bandura (1977) seems very promising for health counseling since it recognizes the inter-connections among cognitive, physiological, behavioral and environmental factors. Use of this model would allow attention to be given, for example, to thoughts, self-talk, and beliefs (cognitions); to heart rate, blood pressure, and hormones (physiology); to speech and motor actions (behaviors); and to work, community, others at home, and physical settings (environment).

They think that this comprehensive model would contribute to the development of procedures for helping people to take a stronger sense of personal responsibility for their own health care and for discovering methods to facilitate personal health problem solving. Such strategies are being brought to bear on a range of important health care issues, including weight control and maintenance, stress reduction and maintenance, "healthy heart" nutrition, smoking prevention and cessation, hypertension control, physical fitness programs, and buckling seat belts when driving or riding in an automobile. Although the numbers of counseling psychologists currently providing health counseling appears

to be relatively small (Zytowski, 1985), the primary preventive potential of helping people to increase their personal responsibility and involvement in health care is enormous (Stensrud & Stensrud, 1982). Many roles are available, including those of psychological educator, nutritional consultant, change agent, human resource developer, hospice worker, behavioral self-management trainer, and multimodal behavior therapist (Southern & Hannaford, 1981).

The second strategy that seems fertile for primary prevention in the health counseling area is for professional counselors and counseling psychologists *to introduce counseling and interpersonal skills into the health care environment.* Kagan (1980a) has elucidated this approach, which appears to have at least two main directions. In the first, counseling practitioners and other helping professionals are becoming employed by hospitals and medical groups to provide direct services to patients. The second approach, though, is what I want to expand, since it holds the greatest impact for primary prevention.

In this approach, counseling practitioners have been consulting and training with health care providers, often with physicians, to teach them the kinds of counseling and interpersonal skills they need to interact more effectively with their patients. As Kagan so well observed, "The physician comes closer to being a powerful, omniscient figure than most other people in the patient's life" (p. 484). Therefore, what follows is that how and what the physician communicates to patients frequently can have meta-effects. Since many health care providers have recognized that effective and sensitive human interaction can aid the healing process, some have become interested in improving their own skills through training and consultation.

Kagan has identified the sorts of skills that he has found to be most useful to the physician. Although they will not be discussed here, the skill areas subsumed under these categories are response modes, knowing, patient feedback, understanding, the process as content, continuing education, and external review. He then uses his interpersonal process recall (IPR) method to teach physicians the skills contained in these areas.

Of course, the idea is that this sort of skill training (which, incidentally, you probably can relate directly to the psychoeducational helping skills section that we discussed earlier in this chapter) will enable physicians to become more adequate care-givers, thus serving to enhance, rather than to detract from, the healing process. Anyone who has seen

the television program, "St. Elsewhere," would not doubt immediately nominate the bombastic and insensitive surgeon, Dr. Craig, for such skill training if they could.

Thus, whether through helping people to gain greater self control over their health, or through training health care professionals in counseling skills, health counseling provides a cogent direction for conducting primary prevention in counseling. Its expanded use depends on interested and competent counselors becoming engaged.

SUMMARY

You have seen in this chapter how primary prevention in counseling is being supported through four different competency-enhancement approaches: (1) ecological; (2) outreach and community counseling; (3) psychoeducational skill development; and (4) health counseling. Each of them profits from a strong theoretical and research foundation and they all contain relatively clear application steps. Importantly, each of them can be used by knowledgeable professional counselors and counseling psychologists to reach primary prevention goals.

As you have seen, also, usage of these and other primary preventive approaches in counseling has lagged. But that situation is not due to the lack of available action approaches. I hope it is clear, following your reading of Chapter 3, that counseling psychology and professional counseling possess the conceptual and technical resources that can allow for a significantly higher profile of involvement in counseling for primary prevention.

The impediment to greater participation in this effort is attributable to other factors. Chief among these is the absence of a coherent model that specifically explains what "primary preventive counseling" is and how it can be accomplished. Such a model could provide the frame of reference that is needed to guide the use of existing concepts, approaches, and interventions in counseling that have primary preventive potential.

Section II of this book contains a model for primary preventive counseling that may provide the kind of conceptual framework that is required to help advance work in this area. Chapter 4 initiates this process by describing the primary preventive counseling model.

ISSUES FOR REFLECTION AND DISCUSSION

1. What are some primary preventive aspects of the ecological model? Of outreach and community counseling? Of psychoeducational skill development? Of health counseling?

2. In the ecological approach, the importance of people interacting with their environment is important. Why? An example was given of a mother, her young boy, and a broken cookie jar. What is the ecological relationship here? Can you give another example to illustrate?

3. What does the idea that a "person's behavior does not occur in a vacuum" mean?

4. What do you think of the ecological contention that environments can be the sources of problems? Are there really such things as "unhealthy" environments?

5. With regard to the outreach approach of Drum and Figler, how is it that a counselor's impact can be multiplied many times over by emphasizing growth and prevention?

6. Explain the concept of "outreach" drawing from the seven steps of the growth and prevention model. Take any one step and develop a practical example taken from your experience.

7. Community counseling means, in part, getting out of the office into the community. How did Lewis and Lewis suggest that this be done?

8. What does the community counseling notion mean that "prevention is more efficient than remediation?" Give an example.

9. According to Lewis and Lewis, community counseling includes community education, community organization, client counseling, and client advocacy. How do these differ? Which approach appeals the most to you?

10. We examined different approaches to psychoeducational skill development. All endorse an educational, as opposed to a medical, training model. What is the difference? What do you think of this?

11. Using Barrow's cognitive development example, show how you might apply it to a stress management program.

12. Skills development approaches were divided into those that work with individual and interpersonal skills and those that work with group, organizational, and systems skills. What are the similarities and differences? Give one example of each major form.

13. Health counseling is a broad term referring to helping people to better manage their own health. What are some parallel terms?

14. Give an illustration of how the "expanded cognitive social learning" model might be applied to working with a group of adults interested in beginning an aerobic exercise program.

15. If you were about to begin a training program on counseling skills for physicians, what basic skills might you include? How comfortable might you feel working with this group?

HIGHLY RECOMMENDED SUPPLEMENTARY READINGS

Ecological Approach

Banning, J., & Kaiser, L. (1974). An ecological perspective and model for campus design. *Personnel & Guidance Journal, 52,* 370-375.

This short article is a classic for applying an ecological perspective to action, in this case on the campuses of higher education.

Insel, P., & Moos, R. (1974). Psychological environments: Expanding the scope of human ecology. *American Psychologist, 29,* 179-188.

The broad scope of person-environment study and practice is sketched here in a concise and understandable way.

Psychoeducational Skill Development

Egan, G., & Cowan, M. (1979). *People in systems.* Monterey, CA: Brooks/Cole.

This book broke new ground in describing how counselors and other helpers could become involved in helping people through system (environment) work.

Ivey, A. (1976). Counseling psychology, the psycho-educator model and the future. *The Counseling Psychologist, 6,* 72-75.

This model provided counseling psychologists with a useful framework for conducting skill development and exerting a primary preventive effect.

Community Counseling

Lewis, J., & Lewis, M. (1983). *Community counseling.* New York: Wiley.

The first edition in 1977, and this second edition, show how the community can become the focus for counselor action.

Health Counseling

Thoresen, C., & Eagleston, J. (1984). Counseling, health, and psychology. In S. Brown & R. Lent (Eds.), *Handbook of counseling psychology,* 930-955. New York: Wiley.

This chapter develops a sound basis for how counseling psychologists and counselors can help people gain greater self-control over health.

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SECTION II

PRIMARY PREVENTIVE COUNSELING AND ITS METHODS

INTRODUCTION TO SECTION II

This section of the book is devoted to defining primary preventive counseling and to examining its four major methods. In colloquial terms, this is the "guts" of the book; it tells what primary preventive counseling is and how it can be undertaken.

Chapter 4, "Primary Preventive Counseling: A Conceptual Model," presents both a definition for this type of counseling and a conceptual model for its elaboration. Briefly, primary preventive counseling is, *"the application of a broad range of counseling methods to any of a variety of at risk targets in order to avert future dysfunction in them by maintaining healthy functioning and good coping skills."* And, as you will see, the model (presented in Chart 4.2) enables primary preventive counseling to be directed at system and person change, using direct or indirect methods, and aimed at targets of the individual or small group, work, family, school, church or synagogue, or community agencies.

Chapters 5 and 6 define the direct methods of education and organizing. Chapters 7 and 8 define the indirect methods of consultation and use of the media. Each of these major direct and indirect methods is accomplished through interventions that are detailed in their respective chapters.

Chart II.1 is provided as a pre-organizer. In it are displayed methods and interventions of primary preventive counseling.

These methods and interventions should strike a responsive chord in most practicing counseling psychologists and professional counselors. Some of the interventions, such as use of mass media, may seem rare, if not somewhat strange. The total package of interventions may strike some readers as being overwhelming, while others may see it as offering exciting possibilities for counseling practitioners in their efforts to conduct primary prevention.

Of course, I am in the latter camp. But I wonder where you will be? I encourage you to actively read and consider chapters 4 through 8, as they will expand the material contained in the previous chart. I would be very interested in your thoughts and reactions.

DIRECT METHODS

Education Interventions	**Organizing** Interventions
Expert witness	Community development
Translator	Social and political action
Activist-Collaborator	Organization development
Ecological counseling	Task group facilitating
Informational dissemination	Administration
Training	Helping groups
Caregiver training	

INDIRECT METHODS

Consultation Interventions	**Media Usage** Interventions
Mediation	Mass media
Networking/Coalition building	Media plus Intentional Personal Support
Advocacy	
Technostructural change	
Action research	
Environmental design	

Chart II.1. Methods and interventions in primary preventive counseling.

CHAPTER 4

A CONCEPTUAL MODEL

An oxymoron, according to Webster's *Dictionary*, is a "combination of contradictory or incongruous terms." Webster's gives the example of "cruel kindness." Let me suggest some others that also may qualify: jumbo shrimp, holy war, quiet desperation, tough love, benign neglect, low inflation, perfect fool, fast food, iron maiden, gentle giant, and chronic crisis. (Actually it's fun trying to think of oxymorons; I recommend it for your spare time!)

These examples illustrate the curious juxtaposition of opposing words that have been linked to create new entities or new understandings. An oxymoron is a kind of word-play, a creative use of the language to evoke new images. And I find that when I think about each of the words in an oxymoron, I am somewhat unsettled, sort of discombobulated, by their apparent unnatural relationship.

Think, for example, of the oxymoron, "benign neglect," which has been used to sometimes describe the treatment of the less powerful by the more powerful. Again, according to Webster, the word "benign" means gracious or favorable, while the word "neglect" means to disregard or carelessly unattend to another. Thus, the juxtaposition is produced: How can one "graciously disregard" another? The words rub, jammed together like the wrong pieces of a puzzle, but they yield a new meaning that becomes descriptive.

But, is primary preventive counseling an example of an oxymoron? That is, are the words "preventive" and "counseling" contradictory and

1.6

incongruous, as the definition of an oxymoron requires them to be? And, if so, would that explain the puzzlement that many seem to feel when they first hear the term? Or does the term primary preventive counseling describe a genuine form of counseling that is simply unfamiliar to many, possessing, as the marketers of a relatively unknown political candidate might say of him/her, "low recognition value?"

Whether one considers primary preventive counseling to be an oxymoron or a genuine form of counseling depends upon one's understanding of counseling itself. An explanation will be given by describing a conceptual model of counseling, commonly called the "Counseling Cube" by those who know of it.

DIMENSIONS OF COUNSELOR FUNCTIONING

First, a personal confession. When the "Dimensions of Counselor Functioning Cube" of Morrill, Oetting, and Hurst was published in 1974, my professional life was forever (I expect) changed. What I had pretty strongly suspected, and had been practicing to some extent in my work as a counseling center counseling psychologist, was validated by the contents of the Cube: Counseling was not restricted to a remedial process occurring between a skilled professional counselor or psychologist and one other person needing help. Instead, counseling was a kind of "multisplendored thing," capable of being employed in a variety of ways, for different reasons, and with a range of recipients. Certainly, counseling included one-to-one remedial activity, but, according to the Cube, it also legitimately embraced such other activities as community consultation, training and supervising paraprofessional helpers, and using a variety of media (e.g., newspapers, television, computers) to reach a targeted audience with a preventive message.

Yes, for me the Cube model served to organize counseling in a way that invited innovation, thus greatly expanding its potential. This model virtually exploded conceptions of what counseling was and of what it could do. This is so because 36 counseling interventions are generated by the Cube, not just the one intervention of individual, remedial, direct service (that is, the traditional understanding of counseling). And, moreover, the place of *prevention* in counseling was ratified, because it stood alongside remediation and development as a full partner.

The prominent inclusion of prevention (especially primary prevention) in the Cube brings us back to the question posed earlier. Is primary preventive counseling a genuine form of counseling or is it an oxymoron, that is, a creative bundling of contradictions? The answer, I think, is that primary preventive counseling is a genuine, actual form of counseling, albeit existing in an underpublicized, unorganized, and undersubscribed state. An oxymoron it is not.

Defining the Cube's Dimensions

Because the primary preventive counseling model emerges from the Cube, one needs to be knowledgeable about the dimensions of the Cube first. Therefore, a brief look at these dimensions is provided to set the stage properly.

Morrill, Oetting, and Hurst (1974) pictured counseling interventions to consist of three main dimensions: Their targets, purposes, and methods. As they wrote, counseling interventions are comprised of the following:

> *The Target of the Intervention.* Interventions may be aimed at (a) the individual, (b) the individual's primary groups, (c) the individual's associational groups, or (d) the institutions or communities that influence the individual's behavior.
>
> *The Purpose of the Intervention.* The purpose may be (a) remediation, (b) prevention, or (c) development.
>
> *The Method of Intervention.* The method of reaching the target population may be through (a) direct service, which involves direct professional involvement with the target; (b) consultation with and training of other helping professionals or paraprofessionals; or (c) indirect interventions utilizing media, i.e., computers, programmed exercises, books, television, and other media.
>
> Any intervention has these three dimensions: who or what the intervention is aimed at, why the intervention is attempted, and how the intervention is made. (pp. 355-356)

Importantly, the authors added a postscript to their discussion of these dimensions—that is, the counselor functions of assessment and evaluation override all three dimensions. They rightly observed that decisions relating to the proper selection of purpose, method, and target are all based on effective assessment procedures being used. Likewise, whatever counseling intervention is attempted must be subjected to appropriate evaluation procedures to determine program effects. Realistically, the considerable promise of the Cube is dependent upon a

thorough grounding in assessment and evaluation procedures, just as is any other counseling model.

The Cube model for counselor functioning not only provided a conceptual mechanism for organizing and understanding alternative modes of intervention. It also served the important function of stimulating counselors to consider the interrelationship of intervention targets, methods, and purposes in order to select and use the combination carrying the highest probability for counseling success. Use of this model spurred on creative thinking about differential counseling approaches as well as the planful evaluation of what was done.

THE CUBE AND ITS PREVENTIVE APPLICATIONS

Since the Cube has four levels of intervention target, three levels of intervention purpose, and three levels of intervention methods, 36 possible counseling interventions (4 x 3 x 3 = 36) are produced from all interactions of target, with purpose, with method. With regard to the preventive domain particularly, which is the focus of our attention, the Cube model allows for the possibility of 12 preventive interventions. In Chart 4.1 are depicted these general possibilities for prevention, which emerge from the 12 combinations of target and method.

To illustrate use of Chart 4.1, two theoretical examples will be provided. The first entry of the Chart suggests the possibility of a direct service method being delivered to an individual target in order to meet preventive goals. This could occur when a professional counselor meets with a university faculty member who is going up for tenure consideration in the next six months. The counselor helps the individual to create an appealing alternative career plan that stands a good chance for successful implementation, in case the tenure quest fails.

The last entry of Chart 4.1 suggests that media can be used in a community or institution to reach some specified preventive ends. Such a situation could happen when a professional counselor, in combination with a public education television station, creates and delivers a ten-week television program on community development skills for formal and informal community leaders. As an integral part of this community-media intervention, these leaders meet in small groups to discuss how they could apply the televised material to increase the participation of senior citizens in community life. Achieving this preventive goal is based on the

idea that active community involvement can serve as a general antidote to psychological and physical deterioration.

Target Dimensions	Method Dimensions
Individual	Direct Services
	Consultation & Training
	Media
Primary Group (e.g., family)	Direct Services
	Consultation & Training
	Media
Associational Group (e.g., club)	Direct Services
	Consultation & Training
	Media
Institution or Community	Direct Services
	Consultation & Training
	Media

Chart 4.1. Twelve preventive intervention directions based upon the Cube model.

As can be seen, the preventive aspects of the Cube provide a good, basic framework to guide action. Now let me provide some actual examples of how it has been used. Colleagues and I have been involved with a lot of activity over the years that we intended to be preventive, and which were planned in keeping with the general dimensions of the Cube. At the Illinois State University Student Counseling Center in the late 1970s, and in the Office of Student Life at the University of Cincinnati during the 1980s, whenever possible we have been seeking to strengthen the competencies of students while also altering selective negative conditions of campus life.

For instance, we took to heart the selection, training, use, and supervision of student paraprofessionals as an important part of an overall campus prevention program. This approach, of course, stems from the "consultation and training" method of the Cube interacting with a campus "community" target. The use of paraprofessionals has taken many forms over the years, but I will mention just two of them here.

In one major project, conducted at Illinois State University and reported in several sources (e.g., Conyne, 1975, 1978), we taught 75 paraprofessionals to become campus environmental assessors. On a monthly basis over the course of a few years these trained observers used an assessment device of our creation, the Environmental Assessment Inventory, to provide detailed quantitative and qualitative information about the observed effects of the campus environment on students. We systematically gathered information about these sub-environments: academic (e.g., classroom aspects), social (e.g., interracial relationships), physical (e.g., meeting space availability), policies and procedures (e.g., drop-and-add procedures), and social climate (e.g., faculty and staff attitude toward students). Counseling Center consultants then communicated this information through specially focused written reports and consultations to appropriate university department personnel in an effort to inform them of student perceptions and to facilitate further examination of environmental conditions, where necessary. In some instances, for example, in the insertion of an academic mid-year break to alleviate the build-up of excessive student stress, this process led to significant environmental change that was intended to benefit student growth and development.

In a second approach, virtually an entire academic support service at the University of Cincinnati is based on student paraprofessional

delivery. This approach was born as much out of necessity (severe budget reductions) as it was out of a belief in the importance of a student-to-student helping model (e.g., Ender, McCaffrey, & Miller, 1979). The Educational Advising and Orientation department of the Office of Student Life offers tutorial assistance, summer and fall orientation programs, commuter information, advocacy, and referral services, student organization development services, and a broad range of educational advising for undecided students—nearly all through the efforts of highly trained and closely supervised undergraduate and graduate students. Moreover, the academic support and, some maintain, survival skills provided by these paraprofessionals are directly tied to the prevention of academic failure.

These two modes of intervention, both of which make heavy use of paraprofessionals, illustrate how the Cube model has been applied in my experience to reach preventive goals. It has provided the counseling foundation for the development of a model for primary preventive counseling, that is described in the next section.

A PRIMARY PREVENTIVE COUNSELING MODEL

Definitions of "Preventive Counseling"

The Cube model provided us with the conceptual framework for designing and conducting preventive applications. In a sense, it elaborated the three roles that were suggested for counseling psychologists by Jordaan, Myers, Layton, and Morgan in 1968—remedial, developmental, and preventive—that you encountered earlier in Chapter 2.

Since these contributions, others have mentioned and briefly defined "preventive counseling" itself. For instance, Pietrofesa, Hoffman, and Splete (1984) have identified four counseling types: crisis, facilitative, preventive, and developmental. They see preventive counseling as being programmatic, focused on a particular time span, and related to a specific concern, such as drug awareness, retirement options, or the sex education of elementary school children. In terms of the counselor's role, they state

> In preventive counseling, the counselor may present information to a group or refer individuals to relevant programs. The counselor may also continue to work individually with clients—either on a group or a one-to-one basis. Thus, in the area of preventive counseling, we often find the counselor's work with individual clients being complemented by clients' involvement in other relevant programs. (p. 12)

A second example of how preventive counseling has been described was provided by Belkin (1984). He viewed preventive counseling as one of the several ways in which health counseling is being conducted. As you will recall, health counseling was an instance I discussed in Chapter 3 of how primary prevention is currently being articulated in counseling; this is just the reverse of how Belkin saw the situation.

To help you better understand his position, Belkin viewed health counseling as one of nine major counseling applications. The other eight counseling applications he identified are counseling over the life span, family counseling, group counseling, crisis intervention counseling, rehabilitation counseling, counseling in the schools, career counseling, and cross-cultural counseling. Within health counseling, in addition to preventive counseling, Belkin saw the other important topics as medical-surgical health counseling, nutritional counseling, health and stress control, fertility counseling, problem pregnancy counseling, and alcohol abuse counseling.

Belkin viewed preventive counseling within health counseling as representing the "holistic perspective." In his words

> Preventive counseling brings together individual counseling actions as well as public education and group counseling approaches. Its rationale is that "an ounce of prevention is worth a pound of cure." The holistic emphasis on health as "positive wellness" takes into account all aspects of the person's environmental, physical, and spiritual-interpersonal reality. (p. 395)

Belkin went further to indicate that two general types of preventive counseling approaches, the individual and the public, are present. In working with an individual, preventive counseling is used to find the areas where the person needs information; the presupposition is that the individual is willing to learn how to avoid future problems but does not currently possess the adequate knowledge. He gave this example:

> Susan, aged thirteen, was having sexual relations but not using contraception. She was under the belief that if she confined her sexual relations to the week after her period, she could not become pregnant. Her counselor explained the vicissitudes of fertility and ovulation, and informed Susan about the different

kinds of contraception available. The counselor then referred Susan to Planned Parenthood. (p. 401)

In the public approach to preventive counseling, Belkin suggested that the task is to identify the needs of the audience to which a large-scale information effort will be directed. He illustrated this approach through efforts of a health counselor attempting to inform the public through advertising, brochures, publications in local newspapers, and other media about the range of health resources that are available to them so that they would be better able to remain healthy.

As you have no doubt noticed, these two brief definitions of preventive counseling contain similarities and differences. Authors of each definition agree that preventive counseling is a new type of counseling, although Pietrofesa et al. emphasized its generic aspects while Belkin viewed it as a subsidiary of health counseling. According to both definitions, preventive counseling is employed with not only an individual, but also much more extensively. It is used frequently with groups and large collections of people. Further, concurrence exists that preventive counseling often involves bringing information to people in order that they may be able to cope more effectively in any number of ways (Pietrofesa et al.) or to remain healthy (Belkin). Last, the planned nature of a preventive counseling intervention seems to be a part of each definition.

Interestingly, neither definition reviewed accords a prominent place to system change or to the microsocial component of competency enhancement (see Chapter 2) that have been cited by Cowen (1985) and others as being critically important to primary prevention efforts. Nor does either one include the variety of preventive intervention modes that were made conceivable in the counseling cube of Morrill, et al. that we examined at some length earlier in this chapter. In fact, the Pietrofesa et al. and Belkin definitions of preventive counseling seem to identify only information-giving and referral as the means for conducting preventive counseling. A final observation is that none of these treatments of either preventive intervention or of preventive counseling stress the critical concept of "at risk." That is, those persons or situations constituting the focus for preventive counseling must be shown to be in some degree of jeopardy of experiencing future difficulty; the preventive intervention is conducted to forestall that difficulty from occurring.

Perhaps the most important point to be made however, is that definitions of preventive counseling, however brief and incomplete, are

beginning to appear in the "Introduction to Counseling" textbook literature. There may be no other index that can so readily provide us with evidence of its growing status in the field.

Primary Preventive Counseling versus Preventive Counseling

You may be interested to know that I have been battling internally for some time about the title and focus for this book. The two contestants in this battle have been, on the one side, "preventive counseling," while, on the other side, "primary preventive counseling." I did want very much to clearly distinguish primary preventive aspects from other preventive aspects (secondary or tertiary), and, therefore, leaned from a purist viewpoint toward the longer title and emphasis. However, I found the length of that title awkward and unappealing, causing me to waver toward the simpler (but more vague) language of preventive counseling.

What led me to decide in favor of "primary preventive counseling"—the more complex but more accurate version—was an article I read in the *New York Times* (10/16/86) on school health clinics. Among other things, this article described the 61 clinics that currently operate across the nation to provide sex counseling and reproductive health information, along with other services, to adolescents in low-income areas who might not otherwise never see a doctor or counselor.

This is a trend. The Center for Population Options, a national advocacy group, says that 100 more schools expect to open such clinics despite the controversy that rages in some cities (such as in Cincinnati, where I live) about (the fear of) school-affiliated clinics dispensing contraceptives to teen-agers. Yet, as Comer pointed out in an opening speech to the national conference on school-based clinic that was reported in this article, poverty, large families, low education levels and unconcerned parents force adolescents out of the mainstream of values. The way to change these "structural problems," he said, is to help teen-agers feel connected to the school clinics.

The clincher for me was contained in comments attributed in the article to Healthstart, Inc., a St. Paul, Minnesota school clinic. This clinic was said to be providing counseling on family planning and *primary prevention counseling* (italics inserted), where self-esteem, problem-solving, and decision-making are stressed. Seeing the term in print, at-

tached to an effort which does indeed appear to be directly in line with what primary preventive counseling is all about, convinced me to proceed with its use, also. I believe that professional textbooks need to lead the way for practice rather than to follow it.

Most importantly, as I hope to have shown by now, is the need to distinguish primary preventive counseling and preventive counseling. This distinction is more than a semantic exercise. Although several differences exist between primary preventive counseling and preventive counseling, perhaps the key one is that primary preventive counseling is used by professional counselors and counseling psychologists with at risk persons before-the-fact, prior to the settling in of disturbance in those same individuals. As well, it is usually used with groups or large collections of people, although it can be employed with one individual at a time. While preventive counseling could be used in these ways, too, it is simply too broad and nebulous a term, for "preventive" can also refer to secondary and tertiary-level correction efforts.

Defining Primary Preventive Counseling

With the preceding as a background, let us turn more directly to considering primary preventive counseling itself. Primary preventive counseling, as its name implies, is a type of counseling. In that sense, I whole-heartedly agree with the general perspective of Pietrofesa et al. (1984) who, as you have read, divide counseling into four types: crisis, facilitative (frequently called remedial), preventive, and developmental (life-span). And I certainly agree with their statement, "One would hope that, in the future, professionals will be able to expend as much time and effort in developmental and preventive counseling as they do now in the crisis and facilitative areas" (p. 14).

In addition to being a type of counseling, primary preventive counseling represents a marriage between two heretofore separate fields of knowledge and practice: Primary prevention and counseling. One can very easily see this joining together in the term itself—"primary preventive," plus "counseling." This is why so much material has been presented in early chapters about primary prevention (Chapter 1) and about the place of prevention in counseling (Chapters 2 and 3).

In my opinion, primary prevention has been long on conceptualization and research and relatively short on practical means for accomplishment. Its advocates claim that primary prevention provides a completely new perspective for help-giving, one that breaks with the historical tradition of reparation by attempting to help at-risk-persons stay healthy.

I accept the preceding claim and add three other assumptions: (1) that the application of primary prevention concepts can stand to benefit greatly through incorporation of counseling methods; (2) that counseling can profit, perhaps even more so, through incorporating primary prevention concepts, thereby reinvigorating its original preventive thrust; and (3) that, most significantly, the successful integration and application of primary prevention and counseling will multiply the positive effects on people who are served.

This "marriage" of primary prevention and counseling can work, however, only if the counseling partner is broad and flexible. The narrow scope of traditional counseling is inadequate to this task. The counseling Cube of Morrill et al. (1974), that was summarized earlier in this chapter, is one model that sufficiently meets the necessary criteria. It provides for a variety of targets (from the individual to the community), and a range of methods (from direct to indirect)—all capable of being used for preventive purposes.

With the preceding background and assumptions, the succinct definition for primary preventive counseling is *the application of a broad range of counseling methods to any of a variety of at-risk-targets in order to avert future dysfunction in them by maintaining healthy functioning and good coping skills.*

A CONCEPTUAL MODEL FOR PRIMARY PREVENTIVE COUNSELING

A model for primary preventive counseling will be helpful for advancing the use of this type of counseling. Not unsurprisingly, the model that I present in the remainder of this chapter draws from primary prevention, particularly the work of Cowen on competency enhancement approaches to person change, and from counseling, especially the counseling Cube of Morrill, et al.

Generally, primary preventive counseling can be thought of in terms of the three dimensions of the Cube: purposive strategies, targets, and methods. That is, from what are the intentional plans that primary preventive counseling draws to reach its goals (its purposive strategies)? What are the ways that these purposive strategies can be employed (its methods)? And what level of people and setting will be addressed by primary preventive counseling (its target)?

In Chart 4.2 is outlined the Primary Preventive Counseling Model to be discussed. Note that in Chapters 5 through 8 to follow, the focus is on primary preventive counseling methods in detail.

DIMENSIONS	LEVELS
Purposive Strategies:	System change approach
	Person change approach Situational focus Competency enhancement focus: Microsocial change Skill development
Methods:	Direct Services Education Organizing
	Indirect Services Consultation Media
Targets:	Individual and/or small group Family Work School Church, synagogue, etc. Community agencies

Chart 4.2. Primary Preventive Counseling Model.

Purposive Strategies in Primary Preventive Counseling

The overall purpose of primary preventive counseling is that of primary prevention itself: to reduce the incidence of dysfunction in a designated collection of people. Said very simply, primary preventive counseling is used to lower the probability of human suffering and to increase the opportunities for human productivity, health, and satisfaction.

But these words are too lofty; they need to be made more operational in this model. To do that *purposive strategies* are discussed; that is, the major plans that are designed to guide primary preventive counseling activities.

Two forms of purposive strategies are used. In the first, *system-change* is sought to remove societal impediments to leading a full life. In Chapter 1, you may remember, such barriers as poverty, illiteracy, unemployment, and malnutrition were cited as prominent examples. System-level change is the paramount strategy for the attainment of primary preventive counseling goals. Yet it is the most complex, demanding, and frustrating to attempt. It is the furthest removed from existing methods and roles and from the training of counseling psychologists and professional counselors. These reasons have prevented system-level change from being frequently attempted.

The second class of purposive strategies is called *person-change.* As described by Cowen (1985) and summarized in Chapter 1, person change is attempted in two major ways. The first, called a *situational* focus, seeks to aid people faced with a stressful life event (such as divorce) to more adequately cope with it. In that sense, the situational focus is said to be reactive (Cowen, 1985). The second major focus is called *competency enhancement.* It is used to proactively develop assets and strengths in people (skill training), or to modify social environments that are inhibiting healthy functioning (microsocial change).

Many aspects exist to commend the situational-focused approach to person-change. The research evidence is building impressively to show it to be a most promising avenue. Yet, the competency enhancement mode of person change appears at present to be most amenable to primary

preventive counseling. Its proactive emphases on skill development and on microsocial change are particularly consistent with the ethos and training of the vast majority of counseling psychologists and professional counselors. Here counseling practitioners can make their most immediate impact on primary preventive counselors. For this pragmatic reason (and that of space) subsequent discussions of person change methods will be limited to the competency enhancement approach.

Methods in Primary Preventive Counseling

Two major classes of methods are used to carry-out the purposive strategies of system-change and of person-change. These are called direct and indirect services. *Direct services* place the professional counselor in personal contact with the target. With *indirect services,* however, the counselor works through other people or through systems to reach the target. A brief overview of these methods is supplied in this Chapter. Much greater attention will be given in succeeding chapters.

Direct services have been the forte of the counseling psychologist for generations. They provide the greatest counselor control in the helping endeavor and they allow the professional person to exert the most personal influence. In *education* is found the largest category of direct services (Ketterer, 1981; Ketterer, Bader, & Levy, 1980). Individual and group counseling, the "bread-and-butter" of the counseling practitioner, represents the educational approach to direct services very well. In the primary preventive counseling model, individual and group counseling, as well as a number of other direct, face-to-face involvements, are categorized under the rubric of education.

The second category of direct services is called *organizing* which involves the counseling practitioner in a number of activities with the intent of mobilizing target members to take action for improving their situation. The facilitation of helping groups represents one instance of organizing.

Indirect services are much newer on the counseling scene. Therefore, more will be said about them here. Many counseling practitioners intuitively dislike these services because they place the counselor once or twice removed from target members. For the most part, counselors have been attracted to the field because they both enjoyed and were effective at working directly with people in a helping way. Yet, as you read in Chapter 1, the imbalance in supply and demand for counseling has led

many professional counselors and counseling psychologists to experiment with new ways to extend their reach.

Therefore, indirect services have emerged to assist in expanding the impact that any one professional counselor or counseling psychologist could be expected to exert. The idea is that by working in a one-to-one situation, any single counselor is limited to only a few client contacts per work day. When working through others or when using informational systems to reach designated targets the same counselor's impact—at least theoretically—is multiplied.

Two classifications of indirect services are available for use in primary preventive counseling. These are (1) the various forms of consultation and (2) the range of media.

In *consultation,* the professional counselor or counseling psychologist is usually involved in a triadic effort (Gallessich, 1982, 1985; Kurpius & Brubaker, 1976). The consultant (Point "A") works through others (Point "B") to benefit a third party (Point "C"). This demonstrates the indirectness of the triadic process of consultation.

One frequent way in which this triadic orientation is implemented can be found when a counseling psychologist consults with the "manager" of a situation or organization (e.g., the teacher of a classroom, the director of a corporation, or a guidance counselor working with a particular student) to enable that manager to improve his/her effectiveness in working with the situation or organization. The consultant's focus is on improving the work of the consultee (the "manager"). Through consulting with the manager the third party benefits.

Therefore, in addition to a triadic orientation to helping, consultation is also characterized by its primary focus upon professional or work problems (Bardon, 1985). This work emphasis serves to further delineate consultation from other modes of helping, especially clarifying it from the personal orientation of psychotherapy.

Consultation is a critical indirect intervention in primary preventive counseling. I will say much more about it in Chapter 7, which will focus on consultation.

The use of *media* by professional counselors and counseling psychologists is an untapped resource, although one that is certainly not without potential harm. Klonoff (1983) observed that the scope and efficiency of the media as a mass communication vehicle make it a natural for conducting public education that has as its goal the prevention of human problems. The work by Maccoby and Alexander (1979), on reducing heart disease risk through a media campaign, affords one stellar example of what is possible.

Media include the gamut of possibilities that exists today, from the traditional forms of books, newspapers, and pamphlets to the innovative forms of computers, cable television, and video cassettes. Use of the media to reach a target population is clearly indirect; the counseling practitioner works through a communication channel of some kind. It offers cost efficiency, as whole masses of people can theoretically be reached. Yet it nearly completely removes the counselor from personal contact with members of the target population, and its use must be carefully safeguarded through giving special attention to ethical considerations (Klonoff, 1983). As a multiplier of counselor impact, though, the mediated approach is unbeatable. In Chapter 8 the focus is on this indirect method in detail.

Targets in Primary Preventive Counseling

As was indicated in Chart 4.2, the targets for primary preventive counseling include the individual and small group, as well as other broader cultural systems that are prominent in this society: family, work, school, churches and synagogues, and community agencies. These settings are major enculturators in American life. They are where most of us spend most of our lives, and, as has been noted, they contribute greatly to personal satisfaction or lack of the same.

One of the critical strategic problems facing the delivery of primary preventive counseling is, simply, how to do it (Conyne, 1983). When I explained to a new acquaintance the other day that counselors can work in ways to prevent the occurrence of dysfunction in peoples' lives, she thought that was a wonderful idea, but quickly asked the inevitable question: "How do counselors get involved with people *before* they have problems?" (I have heard this very good question more times than I can remember!) Indeed, as Remer, Niguette, Anderson, and Terrell (1984) observed about this issue:

> Primary preventive interventions must have an effective, efficient delivery system. In the past, even with cogently compelling interventions (e.g., floridation), implementation has met stiff resistance. An effective delivery vehicle is a *sine qua non* in the mental health area, where values conflicts are rife and the necessity for a particular intervention is not nearly so clear-cut. (p. 30)

As you will recall from earlier reading in Chapter 1, the targeting of settings, or situations, has been recommended for primary preventive intervention (e.g., Dohrenwend & Dohrenwend, 1974; Price, 1974; Price, Bader, & Ketterer, 1980). In particular, they have suggested that "high risk situations" become the focus for such attention. Of course, such an approach is entirely consistent with an ecological perspective, which argues for viewing people in the contexts of their lives.

These contexts, situations, or settings show high promise for primary preventive counseling because they are powerful shapers of human behavior and they provide access points for the potential delivery of primary preventive counseling interventions. So, in response to my new acquaintance (and others who wonder about this question), I talk of how counselors can help to prevent human problems through involvement in the major settings of human life in this society.

The kinds of involvements possible are those direct and indirect services previously discussed and are elaborated upon in Chapters 5 through 8. The major settings have been identified differently by authors. For instance, in the edited book by Price, Ketterer, Bader, and Monahan (1980), the settings of schools (see Jason, 1980), diversion programs, such as juvenile justice (see Vandenbos & Miller, 1980), industry (see Foote & Erfurt, 1980), and social networks (see Gottlieb & Hall, 1980) were proposed. Remer et al. (1984) suggested what they called a "metasystem" for the delivery of primary preventive interventions. This metasystem includes the delivery vehicles of the family, church, and school. Of course, the counseling Cube (Chart 4.1) identifies as targets the individual, primary group, associational group, and the community or institution. Finally, Pearson (1985) stresses the importance of including the individual and small group as viable primary preventive targets. He maintained that because many standard definitions of primary prevention exclude the individual and small group form consideration (i.e., most of them emphasize populations or, less frequently, settings), many counselors miss the opportunity to turn individual and small group counseling in the direction of primary prevention.

The target settings included in the model for primary preventive counseling presented in this chapter draw from the previously listed contributions. The individual and small group, the family, work, school, churches and synagogues, and community agencies all contain fertile social environments in which primary preventive counseling efforts can be launched (Vincent & Trickett, 1983).

SUMMARY

In Chapter 4 are contained the basic ingredients for defining primary preventive counseling and for conducting it. Primary preventive counseling is defined as, "the application of a broad range of counseling methods to any of a variety of at-risk-targets in order to avert future dysfunction in them by maintaining healthy functioning and good coping skills." The hope is that this definition and the "Primary Preventive Counseling Model" will contribute to a better understanding of what this type of counseling is and will provide a useful kind of road map in guiding future action.

All new models are built on the shoulders of previous thinking. So the situation is with this model, which integrated various concepts from primary prevention with those from professional counseling and counseling psychology. Of particular importance were the works of Cowen on competency enhancement in person change and of Morrill et al. on the counseling Cube. Other important conceptions of "preventive counseling" were highlighted in the chapter.

The product of this integration, the primary prevention counseling model, contains the dimensions of (1) purposive strategies, (2) methods, and (3) targets. Each of these dimensions was economically described in the text, and in Chart 4.2 is presented an outline of the model itself.

The next important step is to move from the abstraction of a conceptual model to the more practical level of its use. Subsequent chapters of Section II will begin to do this by focusing on the methods for conducting primary preventive counseling. Chapters 5 and 6 will address the direct service interventions of education and organizing, while Chapters 7 and 8 will take up the indirect service interventions of consultation and media.

ISSUES FOR REFLECTION AND DISCUSSION

1. Why is competency enhancement in person change the most promising for immediate application of primary preventive counseling?

2. How is primary preventive counseling defined in the chapter? Identify any questions or unclarities you may now have about it.

3. What are some of the major ideas from primary prevention and from counseling that have contributed to primary preventive counseling?

4. How do preventive counseling and primary preventive counseling differ? In what ways might they be similar?

5. In general, outline the "Primary Preventive Counseling Model" that was presented in this chapter.

6. What is meant by "purposive strategies?" What are they in this model?

7. What is the main difference between direct and indirect methods of intervention in primary preventive counseling? Give an illustration of each. Identify the direct and indirect interventions that are part of primary preventive counseling.

8. What do you imagine might be some reasons for concern about the use of media in primary preventive counseling? Try giving an example.

9. Early in the chapter was contained a discussion about primary preventive counseling as an oxymoron rather than a genuine form of counseling in its own right. What was that discussion all about?

10. The "target" in primary preventive counseling is sometimes defined with reference to at-risk-settings. Why is this so and what are these settings?

HIGHLY RECOMMENDED SUPPLEMENTARY READINGS

Conyne, R. (1983). Two critical issues in primary prevention: What it is and how to do it. *Personnel and Guidance Journal, 61,* 331-334.

> This article tackles the difficult matters of defining primary prevention and then of putting the major elements of the definition into action. It emphasizes working with at-risk-situations in a multifactoral approach.

Cowen, E. (1985). Person-centered approaches to primary prevention in mental health: Situation-focused and competency-enhancement. *American Journal of Community Psychology, 13,* 31-49.

> The description of competency enhancement approaches to primary prevention contained in this article provides guidance for how professional counselors and counseling psychologists can undertake primary preventive counseling.

Morrill, W., Oetting, E., & Hurst, J. (1974). Dimensions of counselor functioning. *Personnel and Guidance Journal, 52,* 354-359.

> This article, which provides the conceptual foundation for the special issue of which it is a part (C. Parker, Special Editor, "Thirty-Six Faces of Counseling"), develops a framework that greatly extends counseling into innovative areas. It gives rise to the subject of this book, primary preventive counseling.

Price, R., Ketterer, R., Bader, B., & Monahan, J. (Eds.). (1980). *Prevention in mental health: Research, policy, and practice. Beverly Hills: Sage.*

> This edited book addresses, among other topics, the issue of targeting preventive interventions to at risk settings and it contains several chapters which provide examples of how this can be accomplished.

Remer, R., Niguette, G., Anderson, G., & Terrell, J. (1984). A meta-system for the delivery of primary preventive interventions. *Journal of Counseling and Development, 63,* 30-34.

> These authors make a case for the delivery of primary preventive interventions through important cultural settings, namely the family, the schools, and the church. They argue that such an approach would allow for the kind of delivery system so long lacking in primary prevention.

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CHAPTER 5

EDUCATION: A DIRECT METHOD

As stated in the brief discussion about direct methods in Chapter 4, they serve to bring the professional counselor or counseling psychologist into face-to-face contact with the target. No intermediary person or systems are involved.

The Primary Preventive Counseling Model outlined in Chapter 4 includes two direct methods. These two direct methods are (1) *education* and (2) *organizing*. Each of these direct methods is capable of being used to activate the purposive strategies of system change or person change. As well, each direct method can be applied within any level of target suggested by the model. These target levels, as you will recall, include the individual or small group, family, work, school, churches and synagogues, and community agencies. Chapter 5 is focused on education as a direct method.

EXAMPLE: AIDS PREVENTION EDUCATION

Education and prevention share a hallowed tradition. The two have been linked, such that they occupy the same side of the same coin in most people's thinking. A current example of how closely education and prevention are associated can be found in the AIDS (Acquired Immune Deficiency Syndrome) situation in this country.

By conservative estimates, the cumulative death toll resulting from the AIDS virus will reach 179,000 by 1991—more deaths than Americans suffered through the combined effects of World War I and the Vietnam War. With no cure and no vaccine in immediate sight, the importance of what has been termed, "AIDS-prevention education" (and of research) has been stressed.

AIDS-prevention education would amount to a massive national crusade. Its theme would revolve around the practice of what is called, "safe sex." The basic premises of this safe sex educational campaign would be that random sex of any kind is dangerous and that all sex conducted outside monogamous relationships with well-known partners should be accompanied by the use of a condom. As Dr. Stanley Weiss of the National Cancer Institute indicated, "What happens in the next five years will depend on our success in changing people's attitudes and behaviors. If we don't succeed, the virus will continue to spread" (*Newsweek*, 11/10/86, p. 21).

A second educational campaign against AIDS would follow the Surgeon General's recommendation to widely implement sex education in the schools. Particularly emphasized would be education about AIDS, beginning in the elementary schools. Targeting education at young children in the classroom recognizes the critical importance of early intervention conducted in an accessible target setting. Of course, this recommendation, while it enjoys the backing of public health officials and many educators, will need to stand the test of conservative school districts.

These two educational programs—safe sex and AIDS education in the schools—underscore the interrelation of prevention and education. In fact, with regard to combatting AIDS right now and in the immediate future, education *is* prevention. As President Regan stated, "All the vaccines and medications in the world won't change one basic truth—that prevention is better than cure" (Schafer, 1987, p. A-1).

The preceding example was presented to illustrate how education and prevention are so closely linked. I now want to focus on education for primary prevention that is conducted directly to execute the purposive strategies of system- and of person change.

SYSTEM CHANGE

As previously indicated, system change, when it can be accomplished, is the preferred strategy to use for reaching primary prevention goals. Here, of course, one intends to influence the alteration of the basic, underlying conditions and structures of society that can be shown to produce (or, at the least, are highly correlated with) illness and psychopathology. As Caplan and Nelson (1973) noted about the causes and remedies of social problems:

> Whether the social problem to be attacked is delinquency, mental health, drug abuse, unemployment, ghetto riots, or whatever, the significance of the defining process is the same: *the action (or inaction) taken will depend largely on whether causes are seen as residing within individuals or in the environment.* (p. 201)

While psychologists and counselors lean both by inclination and by training to person change (Sarason, 1984), not system change, they can use direct educational approaches to seek basic social change in selected problem areas. As a group, these educational methods are subsumed under the label of "direct involvements with social policy," and they are amenable to primary preventive counseling use.

Influencing the change of social policy that reinforces dysfunctional behavior falls within the domain of primary preventive counseling because a positive change represents a first-order solution. When a professional counselor or psychologist can influence the modification of a basic aversive condition, such as influencing the passage of legislation to benefit a disadvantaged group in society, then that professional person is exerting a primary preventive force.

Those ways in which social policy can be changed through educational approaches are limited. They are restricted to influencing decision makers through the presentation of credible information, and/or the advocacy of a position that is based on such a body of information. Three means are available for the primary preventive professional counselor and/or counseling psychologist: (1) expert witness; (2) translator of psychological, educational, and behavioral science research findings; and (3) activist-collaborator. For the sake of convenience, these educational approaches to system change are presented in Chart 5.1.

Educational Approaches: System Change	Intervention Techniques
Expert witness	Testimony in court cases
	Presentation to decision-making group
Translator	Assuming administrative assistant role
	Accessible to community committees
	Candidate for public office
Activist-collaborator	Facilitate
	Mediate
	Suggest
	Persist
	Initiate
	Research

Chart 5.1. Educational approaches in system change, with illustrative intervention techniques.

Admittedly, these three roles share elements of indirect service; clean-cut distinctions are not always possible to make in practice. These roles have been developed by the Task Force on Psychology and Public Policy (1986) of the American Psychological Association. They emerge from the conviction that psychologists (and, I would add, primary preventive counselors) must become involved in resolving and influencing social issues. As Bevan (1982) has suggested, a "disinterested," neutral psychology is "...immoral, ineffective, and acquiescent to the status quo" (Task Force, 1986, p. 914).

One or two of these three roles may be more possible to put into practice than all three, yet I think it is conceivable that any one of them is suitable for the interested, well-trained professional counselor or counseling psychologist.

Expert Witness

As an expert witness, the primary preventive counselor would appear directly before a public body to communicate his/her professional, expert knowledge on the issue at hand. For instance, testimony might be given to a court on the effects of drug abuse on behavior. Or a presentation might be made to a university Board of Trustees concerned with the quality of student life or the role of active student involvement in learning. The intent of the expert witness is to provide accurate information to decision-making groups in order to influence them to reach positive positions about human behavior. For more discussion about this role, see Eddy, Richardson, & Erpenbach, 1982; and Segall, 1976.

Translator

The role of translator is closely related to that of expert witness, yet it would place the primary preventive counselor in a *continuing* position with regard to a decision-making person or body. One example, offered by DeLeon, Frohboese, and Meyers (1984), is that of a legislative staff assistant to a member of Congress. In another case, one that may be more accessible to most counseling professionals, membership (or chairpersonship) on community committees that are addressing issues of significance for education, mental health, and well-being affords the opportunity to effectively translate relevant scientific concepts and research for practical purposes. For instance, one can become involved in community human relations commissions, school boards, and health committees. A third example, related to the first, is direct involvement in the

political arena as a candidate for public office. (If ex-ballplayers and movie actors can be successful at this, why not ex-counselors and ex-counseling psychologists?) What more propitious place might exist for being able to exert an influence on social policy?

In whatever role selected, the translator attempts to put into jargon-free language relevant findings of psychology and the behavioral sciences. Governmental, grassroots, and other interest groups can then use this information when considering future action.

Activist-Collaborator

As an activist-collaborator (Jackson, 1978), a primary preventive counselor or counseling psychologist intentionally steps aside from a position of value neutrality to espouse and press for the adoption of particular points of view or courses of action that can result in social policy. The activist-collaborator approach is primarily an educational one because, at its heart, it involves the presentation of relevant knowledge to decision makers that is drawn from survey research projects, position papers, demographic data, and other reputable scientific sources.

A colleague and I (Conyne & Lamb, 1978) have argued the merits and deficiencies of this activist role for professional psychologists in relation to campus environmental change. In addition, I have described (Conyne, 1977) the role of "campus change advocate," where the professional counselor performs the sub-roles of (1) initiator of linkages with key campus decision-makers; (2) catalyst, one who may "disturb the peace" to point out policies, procedures, or structures which data indicate are not serving student development; (3) politico, or being able to understand the campus politics and to make them work for positive change; (4) applied researcher, that is, advocating for system change that is derived from adequately produced and formulated applied research data; (5) social architect, being able to collaboratively redesign ineffectual environmental conditions, such as procedures which make internal transferring between colleges in a university extremely difficult to accomplish; and (6) persistent facilitator, or the capacity to ably and patiently communicate on a face-to-face basis with others. Note the following words about the CCA (Campus Change Advocate) that emphasize the need for excellent human relations and educational competencies in directly interacting with others:

> In the final analysis, the CCA's most effective way to advocate appropriate campus environmental change is his or her capability to facilitate, mediate, suggest, summarize, listen, cajole, and persist. Effective interpersonal and group facilitating skills throughout the entire campus change process are mandatory for the CCA, a condition which applies to all counseling interventions. (p. 314)

Summary

In summary, the direct method of education can be used by primary preventive counselors to seek system change. The three approaches presented—expert witness, translator, and activist-collaborator—are all organized under the category of "direct involvement with social policy." Although these approaches offer only a modest potential for effecting social policy change, they do identify roles that can be assumed in this challenging effort.

PERSON CHANGE: COMPETENCY ENHANCEMENT

The available educational approaches for person change—whether for coping with stressful life situations or for competency enhancement—fall well within the boundaries of general counseling practice. *Competency enhancement,* with its attention to microsocial change or to skill development, represents the clearest immediate route for the use of educational approaches in primary preventive counseling. For that reason, as I mentioned before, the focus in this and subsequent discussions of person change will be on the competency enhancement approaches of microsocial change and skill development.

Microsocial Change

Its contribution is similar in kind to the role of educational approaches in system change. The same basic means are used in both cases: expert witness, translator, and advocate-collaborator.

The chief difference in their use is reflective of the basic difference in scope between microsocial and system change. The scope of microsocial change efforts is limited to an identifiable part of a total system. Where system change is concerned with expansive macro-issues, such as the effects of unemployment on a total community, microsocial change efforts are directed at bounded environments, such as how one

place of work in that community might be affected. Because the size and complexity of the microsocial unit is considerably more manageable than the case in system change, the opportunity is increased for educational approaches being used successfully.

A second important difference between system change and microsocial change efforts is that social policy change is not always the goal of the latter. While social policy change may be one goal of microsocial efforts, other goals are frequently selected as well, or instead. These other goals could include changes in organizational structure, in physical facilities, and in staff training and development. More effective organizations and work groups can be produced through any number of ways, while more effective social systems usually require attention to their underlying social policies and values.

Insel and Moos (1974) gave an instance of the use of advocacy-collaboration in microsocial change. They described the role of the "social change facilitator," who is engaged by an organization to collect and interpret social climate data about the organization to help move it to a higher level of functioning. Examples of microsocial settings in which this approach would be suitable correspond to the settings for which Moos and associates have developed their social climate assessment scales, including university residence halls, correctional facilities, elementary classrooms, work organizations, and task groups.

This example of the social change facilitator in microsocial change can be compared with that of the campus change advocate, previously described under educational approaches for system change. The method used, advocacy and collaboration, is basically the same. It is the scope of the environment in which it is employed that varies, along with the broader range of goals that are acceptable for change. This difference in scope can be illustrated by the difference between working on a university residence hall project (microsocial) or on a total campus effort (system change).

Both the microsocial approach in competency enhancement and the system change strategy are used to positively alter unacceptable aspects of social systems. They can be employed by primary preventive counselors to modify environments so that a target population might be allowed to function more ably. In that sense, both approaches embrace the first-order change perspective of changing environments (of whatever scope) to benefit people.

Skill Development

The term, *skill development,* will be used to represent the range of competency enhancement skill building strategies. Through skill development, the counseling professional seeks to strengthen the knowledge and skills of a target group. Doing so, it is thought, will enable these persons to avoid future problems, thus enjoying a healthier life. These skill development initiatives are delivered before-the-fact to a group or population that is defined as being at risk for eventual dysfunction. For example, children of alcoholics, who are generally at high risk for developing alcoholism themselves, can be taught personal and social skills in order to better resist alcoholism.

Four educational approaches are available for developing skills. These are (1) *ecological counseling,* both individual and group; (2) *focused information dissemination;* (3) *competency training;* and (4) *information dissemination to and/or training of caregivers.* In Chart 5.2 are listed these four educational approaches to skill development in competency enhancement.

Ecological Counseling. Whether conducted in an individual or group setting, ecological counseling affords the primary preventive counselor with a means for tying a traditional counseling form to primary prevention goals. I am not talking about traditional counseling here, which tends to focus on personal characteristics to the minimization of environmental forces. No, an ecological approach to counseling by definition includes environmental considerations intimately with personal factors. By doing so, the counselor is able to examine the person-environment transaction. Through such an approach, environmental interventions—conducted by the counseling professional or by clients, with the support of the counseling professional—are legitimized.

Others have written about this perspective of counseling, although its use has not widely overtaken the field by any means! Ecological counseling is implicity included in the counseling cube (Morrill, Oetting, & Hurst, 1974). Vincent and Trickett (1983) have explored how clinical interventions can become a vehicle for primary prevention when they are construed and conducted ecologically. A colleague and I (Conyne & Rogers, 1977) proposed "ecological problem-solving" as a model for psychologists and counselors to consider using in their individual and group counseling and psychotherapy. And Pearson (1985) has provided a conceptual model that is based on ecological properties. In it, he offered

Educational Approaches For Skill Development	Intervention Techniques
Ecological Counseling	Helping client understand environment Helping client understand self in environment Mapping Designing Evaluating
Focused Information Dissemination	Orientation Guidance presentations Presentations to at-risk-group
Competency Training	Interpersonal problem solving Stress reduction Survival skills Guerilla tactics Communication skills Retirement preparation
Caregiver Information and Training	Listening skills Separating content from affect in a message Dealing with confrontation Coping with personal disappointment

Chart 5.2. Educational approaches in skill development in competency enhancement, with illustrative intervention techniques.

guidance for how group workers can conceive and deliver various forms of group interventions to meet the primary prevention purpose of competency enhancement.

Ecological counseling works best for reaching primary prevention goals when it is applied with at-risk-persons. However, *and this is critically important for most counselors and psychotherapists,* it can be employed, also, with those clients who already are experiencing psychological difficulty. As Conyne and Rogers (1977) stated with regard to the prevention and generalizability possibilities of ecological problem-solving:

> Ecological problem-solving, like other approaches to psychotherapy, will most likely begin with a presenting problem. However, the approach is developed for a smooth transition from remediation to prevention, since the development of a client's environmental competency is at issue. The client is taught to apply the ecological problem-solving steps of mapping, designing, and evaluating to the presenting problem and other situations, with the intent that the client may become more environmentally competent in the future. (p. 304)

Here is an example. A woman is arrested for jay-walking. She is brought in handcuffs to the police station where she is frisked and stripped-searched to the accompanying jeers of several male police officers. Because she feels so embarrassed and ashamed about this incident, she enters personal counseling rather than suing the police department for this wanton personal violation and abridgement of her civil liberties.

If you were her counselor, how would you proceed? Would you encourage her to express her feelings and provide empathic understanding? Would you help her to resolve and work through her feelings of embarrassment and disgrace? Would you assist her to examine the environmental causes of her bad feelings? Would you strategize with her about how she could take action to correct the abuses of the police in this case? Would you take some direct action yourself, with her permission, to bring this case to the attention of the police chief?

An ecological approach would require some form of direct attention to the blatant environmental forces that contributed to this client's distress, that is, the sordid behavior of the police involved. Moreover, in primary preventive counseling, an important aspect would be to help this client learn how to better stand up for herself in other situations.

Focused Information Dissemination. Competency enhancement can be advanced, also, through the dissemination of focused information to an at-risk-group. In this approach, the assumption is that being exposed to pertinent information will enable people to avoid future problems in that area.

Of course, this is an oversimplification of life. We all know intuitively that knowledge of risks does not guarantee that risks will not be taken. Otherwise, probably no one in this society today would continue to smoke cigarettes, for example. None of us would drink more than two cups of caffeined coffee a day, in light of recent evidence linking greater coffee drinking with heart disease. And yet, millions of Americans continue to smoke and I will drink three or four cups of coffee a day more often than I know I should. Knowledge and behavior change are not one and the same.

Even so, perhaps because information delivery is a relatively efficient form of intervention, it is arguably the most widely used means of seeking primary prevention purposes. Examples abound. Health and guidance lessons in school classrooms address many issues for which these children are at risk: drug use, cigarette smoking, pregnancy, academic difficulty, and so forth. Orientation programs are offered every Fall to newly entering college and university students to inform them of "all they will ever need to know" to succeed during their college years. Church educational programs are geared frequently to special interests, such as single parenthood, or being single in a world of couples. Nutrition experts fill auditoriums across the country describing diets that people can use to stay healthy. The information may be excellent and the audiences may be intently interested in the content. However, many of these programs fail to produce primary preventive effects because of information overload or because information alone is a deficient approach.

Guidance programs in elementary schools frequently illustrate the provision of focused information to a targeted group (students) in order to prevent the occurrence of later problem behavior (Klingman, 1984). The following is a summary of a guidance program in the schools that relied on this approach, while also including some attention to training (Morgan, 1984).

This guidance program took the form of a mandated curriculum, not as an "extra" that could be offered only if enough time and

resources permitted. It emerged from collaboration among local mental health specialists, school district professionals, and the State Legislature.

Two levels of the guidance program were designed, in recognition of developmental differences among the students: Level A, for grades one, two, and three; and Level B, for grades four, five, and six. These students were targeted for the overall program to help them gain the knowledge and learn the coping skills they needed to competently deal with the fast-changing, complex, high-stress world of today and the future. The thought was that installing this program in the elementary grades would allow for the maximum primary preventive effect.

The curriculum was intended to aid students in reaching three psychoeducational *goals:* (1) to develop their personal selves to the fullest, (2) to exhibit effective interpersonal skills, and (3) to take responsibility for giving direction to their lives. Eight *skill areas* were embedded in the curriculum to help students to meet these goals. These were awareness of feelings, valuing, decision making behavior, listening, cooperation and conflict resolution, occupational/educational decision making, and classroom management. A variety of *curricular materials* were used to help meet the guidance goals and skills. These included, but were not limited to DUSO D-1, SRA Stage Two (Responding), Values Clarification, and 100 Ways to Enhance Self-Concept in the Classroom. This entire curriculum was taught by classroom teachers, with training and support provided by the Mental Health Specialist who was actively involved throughout this program.

Implementation of the guidance curriculum was accomplished in all 36 of the School District's elementary schools. This process took four years. Evaluation data of knowledge gained by participants suggested modest success, and teachers reported that the guidance program contributed to more positive classroom environments. Students were said to be better able to resolve conflicts and teachers spent less time on discipline in the classroom.

Competency Training. Going one important step beyond the provision of relevant information to an at-risk-group is the competency training of at-risk-groups. Training attempts to develop not only knowledge in people but, significantly, the requisite skills that may enable them to act appropriately on that knowledge. Competency training is conducted to improve peoples' present healthy functioning and their overall capacity to withstand future stressors through the augmentation of learned

coping skills. Competency training offers the most feasible and potent educational approach to competency enhancement. A wide range of workshop and other training modes are being used today.

Some of these efforts were described in Chapter 1, when competency enhancement was addressed. Psychoeducation (e.g., Authier, Gustafson, Guerney, & Kasdorf, 1975; Ivey & Simek-Downing, 1980) is a promising approach to the training of target members in needed life skills. People have been trained in the competencies of interpersonal problem-solving, in stress reduction techniques, in survival skills and guerilla tactics for dealing with college faculty, in communications skills for improved relationships, and in a variety of other skills aimed at developing increased wellness and more healthful living.

In one program example of competency training (Tableman, Marchiniak, Johnson, & Rodgers, 1982), stress management training was provided for women on public assistance. A 10-week, 30-hour coping skills training package was administered to enhance these women's self esteem, life planning, and stress management competencies.

Set within an experimental design framework, the results of this program showed significant reductions for participants in psychological distress, depression, anxiety, and inadequacy, as well as significant increases in self-confidence and ego strength. These results are highly encouraging of the competency training approach to primary preventive work.

In another example (Gatz, Barbarin, Tyler, Mitchell, Moran, Wirzbicki, Crawford, & Engelman, 1982), retired adults in the community were taught problem-solving skills and were provided with information about how to better use community resources. Older help-agents were used as facilitators in the program after they received training in intervention and support skills. Program results from this competency training approach found that the help-agents increased their life satisfaction and knowledge of community services, resources and support networks. The retired adults gained in their knowledge of community services and in their sense of personal control, with Black retirees gaining the most in personal control. Again, the effectiveness of this competency training program adds further support to this approach.

Caregiver Information and Training. Education can be used to advance competency enhancement goals through the training of "caregivers" in a setting (Ketterer, Bader, & Levy, 1980; Taynor, Perry, & Fredericks, 1976). Caregivers—whether formal or informal—occupy natural positions of importance in affecting a large number of people's lives. They may be teachers, beauticians, clergy, bartenders, employers, bank tellers, police, and many others. Information and training programs about selected areas of mental health, such as listening skills, separating content from affect in a message, dealing with confrontation, and helping to cope with personal disappointment, can often enable these caregivers to better handle the interpersonal aspects of their jobs. In turn, at least theoretically, the employees or consumers with whom they interact can be helped more and hassled less.

For instance, corporations can help employees and their families to cope more satisfactorily with the potentially devastating effects of being fired. A recent study of the wives of fired executives (Gallagher, 1986) confirms that being fired is a traumatic event for the employee and, also, for the spouse and family. As one wife of a fired executive said, "All our long-range, as well as short-term dreams, came shattering down. The future still seems very bleak" (p. G-1).

Individuals queried in this study offered the following preventive actions that companies could undertake to help ease the sting for spouses who, in this case, were all female: (1) contact the spouse by letter or in person to offer assistance during the post-firing period (the sooner, the better); (2) thank the spouse, either by letter or in person, for her support and contributions during her husband's employment with the firm; (3) explain the reasons for firing to the spouse. These are seemingly simple organizational initiatives undertaken during a time of high personal stress for the spouses of fired executives. However, these steps can help reduce deleterious effects while beginning to promote quicker healing. They illustrate how caregivers, in this case the decision-makers in organizations, can contribute to primary prevention goals.

SUMMARY

Education offers a critically important set of direct methods in primary preventive counseling. While its use for accomplishing system change is somewhat modest, its capacity for facilitating person change

(especially through the competency enhancement approaches of microsocial change and skill development) is very strong. Primary preventive counseling professionals should pay special heed to the approaches of microsocial change, ecological counseling, focused information dissemination, competency training, and caregiver training in their work.

Organizing, the second type of direct method, will be examined in Chapter 6. Its approaches of community development, social and political action, organization development, task group facilitation, administration, and helping groups will be described.

ISSUES FOR REFLECTION AND DISCUSSION

1. Educational is one important direct method in primary preventive counseling. Explain why it is a direct method.

2. Educational approaches to produce system change were referred to as "direct involvements with social policy." Why is social policy so pivotal in these efforts?

3. Expert witness, translator, and activist-collaborator are educational approaches that are used in both system change and in microsocial change. How does their use in each effort differ?

4. Identify and describe the four ways that the educational method is applied in skill development, an important category of competency enhancement in person change. Provide examples of each.

5. Imagine that you are employed as a professional counselor in a human service agency and that you want to begin carrying out primary prevention activities. Knowing what you do about educational approaches in primary preventive counseling, develop a convincing case for persuading the agency director to support your new involvement. Role play this with a colleague.

HIGHLY RECOMMENDED SUPPLEMENTARY READINGS

Conyne, R., & Rogers, R. (1977). Psychotherapy as ecological problem solving. *Psychotherapy: Theory, Research, and Practice, 14,* 298-305.

> This article elaborates how counseling and psychotherapy can be used ecologically to help clients address environmental, as well as personal, considerations. Psychotherapy as ecological problem solving can enable a practitioner to turn a remedial helping situation into a preventive one.

Ketterer, R., Bader, B., & Levy, M. (1980). Strategies and skills for promoting mental health. In R. Price, R. Ketterer, B. Bader, & J. Monahan (Eds.), *Prevention in mental health: Research, policy, and practice,* 263-283. Beverly Hills: Sage.

> This chapter provides a helpful survey of mental health promotion approaches. Its section on a typology of mental health promotion strategies is especially of interest for education.

Tableman, B., Marchiniak, D., Johnson, D., & Rodgers, R. (1983). Stress management training for women of public assistance. *American Journal of Community Psychology, 10,* 357-367.

> This article describes in detail a successful primary preventive intervention with a high risk group. Research results documenting the program's effectiveness are especially impressive.

Task Force on Psychology and Public Policy. (1986). Psychology and public policy. *American Psychologist, 41,* 914-921.

> This article enumerates the ways in which psychologists can become meaningfully involved in the influence of public policy. Also included are examples of such involvements, descriptions of suitable education and training for this kind of activity, and how to locate public policy positions.

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CHAPTER 6

ORGANIZING: A DIRECT METHOD

Professional counseling and counseling psychology arose, to a large degree, from the seeds of early 20th century social reform. The guidance movement that was initiated by Parsons, with assistance from others such as John Brewer, was a central part of efforts then to improve social conditions (Rockwell & Rothney, 1961). Organizing efforts were an important part of social reform and of early guidance efforts.

As Stone (1986) has shown, organizing continues to be a feature of counseling psychology today. To document this position, he referred to the continued (but, I would add, spasmodic) organizing influence in the profession, as evidenced by such recurrent emphases as the counselor as "social engineer" (Stewart & Warnath, 1965), guidance as "social reconstruction" (Shoben, 1962), and orientations embracing "community counseling" (Lewis & Lewis, 1983) and "counseling psychology in community settings" (Blocher & Biggs, 1983).

As a direct method, organizing contrasts starkly with its direct method counterpart, education, that was examined in Chapter 5. You will remember that education is especially suited to enhancing the personal competencies of a target, although it can be used for other purposes, as well. In contrast, organizing is most appropriate for use in seeking system change and in microsocial change, although organizing (through helping groups) is quite useful for promoting competency enhancement, too.

Organizing extends from the assumption that change is accomplished most enduringly through the systems of peoples' lives, especially in groups and organizations, rather than through people as separate individuals. In that sense, organizing focuses on the environmental aspects of the Lewinian equation, which posited that behavior is a function of people interacting with each other and their environment.

As a direct method in primary preventive counseling, organizing consists of six major interventions in system and person change (competency enhancement): (1) *community development* and (2) *social and political action* in system change; (3) *organization development,* (4) *task group facilitation,* and (5) *administration* in microsocial person change; and (6) *helping groups to accomplish skill development* in person change.

Purposive Strategy	Organizing Intervention
System Change	Community Development
	Social and Political Action
Person Change: Competency Enhancement	
Microsocial Change	Organization Development (OD)
	Task Group Facilitation
	Administration
Skill Development	Helping Groups

Chart 6.1. Six major organizing interventions in system and person change (competency enhancement).

SYSTEM CHANGE

At the system-level the organizing approach can achieve change primarily through community development and social and political action. These components are depicted in Chart 6.2.

Jim Barclay, a past-editor of the *Personnel and Guidance Journal,* wrote the following words as part of his introduction to a special issue of that journal on "political action" (guest edited by Solomon, 1982):

> This issue provides us with some guidelines for solidarity and union. We are the people of this nation, and we are witnessing the very destruction of our life, our goals, and the values that support people. Read this issue with care. What it says to us is WAKE UP! and DO SOMETHING! Let this issue speak to us of solidarity and collective action. With its guidelines we may finally begin to emerge from the prolonged "winter of our discontent." (p. 579)

These words echo the call to social and political change that can occur within the community, state, or nation. System change is based on the assumption that human problems result from oppressive social conditions rather than from individual or interpersonal deficits. Thus, both community development and social and political action approaches are used to alter the basic social, economic, and political conditions of society that are thought to strongly influence human health or misery.

As shown in Chart 6.2, the two major approaches of system change are community development, and social and political action. Both forms rely on the involvement and sanction of community members. However, community development and social action differ markedly in their basic assumptions.

Community Development

Community development as an organizing intervention emerges from the mind set that people are basically good and that the presently dysfunctional systems in which they are operating are amenable and generally open to positive change. Thus, a community development facilitator assists community members to become better organized through local initiative, self-help projects, advocacy, and other active participation techniques (Glidewell, 1984). These are examples of *empowerment.* As Christensen put it with regard to community change group work (1985):

Klein (1972) views the group worker involved with the community as a guide, educator and facilitator, a role which requires a high level of patience and sensitivity on the part of the leader. Central to this role of the leader is the advocacy of participation by community members. Most of the literature about leader function, stated or implied, emphasizes that participation in their own solutions by community members is critical. It follows, then, that efforts to facilitate this involvement is a primary function of social action leaders, professional or lay... (p. 269)

Organizing Approaches	Principal Processes	Intervention Techniques
Community Development	Enhancing Collaboration Community members' participation Empowering	Citizen surveys Neighborhood action committees Public hearings Training of community leaders in leadership skills Study circles
Social and Political Action	Creation of community conflict	Gain attention Create conflict Active involvement Provide information to key persons Interview and confront key persons Form coalitions Vote

Chart 6.2. Organizing approaches to system change, with principal processes and illustrative intervention techniques.

Any of a number of community development techniques may be used to promote increased participation. Citizen surveys, neighborhood action committees, public hearings, training of community leaders in leadership skills, and study circles are all examples of how community development is attempted.

Recent illustrations of community development have tied neighborhood discussions to educational television. Stone described the community facilitation discussion groups that were organized to follow-up on the television program, *The Day After,* which depicted the horrors of nuclear devastation. Here, community facilitators gathered diverse members of the community to watch the film, discuss it, and then to develop collective action plans that involved community education efforts as well as lobbying congressional members about this issue.

In another example of this approach, community initiatives to improve literacy in Kentucky were developed after viewing a series of television programs that cogently addressed the astonishing problem of illiteracy in America. Christensen (1983) has discussed how this general kind of approach, which is termed "study circles," can be used to facilitate community development goals.

In a third example, many urban neighborhood groups across the country have organized themselves in "neighborhood watches." In these grass-roots programs, neighbors organize their own resources, in conjunction with the police, for improved crime protection.

Lippitt (1985) has developed a structured task force process in which "shakers and movers" in the community participate to image the desired future of the community and to develop specific plans to move in that direction. He has enumerated 10 principles for community development and preferred futuring that are salient to this discussion, from which I will extract a representative four:

1. To identify and invite key figures from all sectors of community life is crucial, including generation levels, minority populations, male and female representation.

2. To have a significant startup experience with these key figures demonstrating what this process is all about and to give them an opportunity to buy in with adequate understanding and motivation is very important.

3. To provide continuing technical consultation on the design and implementation of this total futuring, planning, and implementation process is also very important.

4. One of the crucial strategies of community organization is to provide for linkage between all the volunteer ad hoc energy of the temporary task forces and the ongoing establishments of the professionals and paid workers of the community structure... (pp. 304-305)

Community development facilitators serve primarily as initial organizers and then as technical advisors to the ongoing work undertaken by community members to solve a common problem. Through their efforts, community development facilitators attempt to augment levels of activity, involvement, participation, and self-determination in community members—in a word, to *empower* them—setting the stage for the latter to take steps necessary for implementing community change.

Social and Political Action

A second important way in which organizing can be used in promoting system change is through social and political action. Where the principal process in community development is enhancing collaborative community member participation, the principal process in social action is the creation of community conflict.

A homely example of social action is found in the case of the farmer who could not get the attention of his mule. He tried every sensible method he knew, from offering the mule's favorite grain to flattery, but nothing worked. The mule continued to totally ignore his pleadings. Finally, in desperation, the farmer simply hauled off and cracked the mule across the forehead with a two-by-four; the mule suddenly became very attentive and obedient! Thus, comes the social action maxim: "To get the attention of those in power, hit them right between the eyes with a two-by-four."

Alinsky (1972) developed the model for social action. In his view, conflict is essential to produce the energy for community change. He believed that while those in power might allow for some change to occur through rational processes, the depth of that change would be hindered by the unwillingness of the "haves" to give up their power. Simply doing

so is not in their self-interest. Alinsky maintained that only through the creation of conflict and the seizing of power can the "have-nots" achieve true community change.

This conflictual approach has been used by the powerless against those in power for centuries. Of recent years in this country, it has been used by college and university students to seek institutional change, by anti-nuclear groups, civil rights advocates, pro-life groups, and by migrant farm workers in California to name just a few cases.

A more sophisticated form of social action is found in its variant, political action. As Solomon (1982) wrote:

> Politics is at the very center of American democracy and government. Those who participate stand to get something out of the system, while those who do not participate stand to gain little and may even lose a great deal. Increasing numbers of helping professionals are becoming acutely aware of the significance political action has on the destiny of the people they serve...Counselors and other human service providers are in a pivotal position to effectively communicate the concerns of people they serve to policy makers at local, state, and national levels of government. (p. 580)

Perkins (1982), a long-time member of the U.S. House of Representatives, suggested five ways that professional counselors could become involved in political action: become aware of future events, provide information to legislators, visit the right legislator to inform and advocate one's views, form coalitions, and vote.

As Perkins pointed out, the days of pet projects with limited constituencies are coming to an end. To maintain desired programs, as well as to muster new ones, alliances need to be formed of like-minded people. These coalitions of constituencies stand a far better chance of success than does the individual pursuit of political goals. These coalitions are taking the form of local political action groups or of alliances of national organizations.

The key to political action is becoming actively involved in the political arena through the ways outlined in preceding paragraphs. By doing so, primary preventive counselors would be able to contribute to the awakening of what Perkins (1982) sensed exists: "...a sleeping giant of educational and social service professionals out there that if roused, could make a tremendous footprint on national policy" (p. 584).

To conclude this coverage of organizing approaches for system change, it should be pointed out that both community development and social and political change are well-suited to the task. However, they are grounded upon two differing sets of assumptions, as you have observed. Primary preventive counselors, who by definition should be among the most interested in fostering and supporting community change, will need to determine how to include these approaches in their job descriptions. Also they must do so in such a way as to be consistent with their training and with good ethical practice.

PERSON CHANGE: COMPETENCY ENHANCEMENT

Microsocial Change

Organizing approaches that are aimed at microsocial units can be used with great success in helping people; as such, they are forms of *competency enhancement*. In fact, the application of organizing approaches in this way is among the most potent interventions available to primary preventive counselors.

It is so potentially potent for three reasons. First, the organizing method, as has been mentioned, leverages interventions. By facilitating positive change in an important organizational unit in people's lives, such as a place of employment, a primary preventive counselor can affect a large number of people—in this case, not only the employees themselves but, also, the quality of products or services that the organization generates. Second, the organizing approaches that are available for microsocial change efforts are extremely well-suited to the task. These approaches will be discussed in this section. Third, well-trained primary preventive counselors are capable of using these organizing approaches for microsocial change purposes; that is, to borrow a phrase from the computer industry, they are quite "user friendly."

For instance, Comer (1985) instituted a microsocial change project (The Yale-New Haven Primary Prevention Project) in the schools to benefit racial and ethnic minority elementary school pupils. The complex environmental intervention included establishing a representative planning and governance group, a parent participation group and program, a mental health team and program, and an academic (curriculum and staff

development) program, all of which interrelate. Results found children involved to have increased academic and social gains when compared with non-program children. As Comer stated, "...the vast majority of children can acquire the psychological, social, and academic competencies needed to function adequately in and after school *when the school environment is adequate* (italics inserted) (p. 155).

What are the promising organizing approaches for microsocial change? Three are available: (1) organization development and its variants, human resource development and total resource utilization; (2) task group facilitation; and (3) administration, or human resource management. These major organizing approaches are contained in Chart 6.3.

Organizing Approaches For Microsocial Change	**Intervention Techniques**
Organization Development (OD)	Data feedback Training Teambuilding Career development Process Consultation (PC)
Task Group Facilitation	Executive function Establishing a caring environment Encouraging innovation and risk taking Attributing meaning
Administration	Assuming an administrative position

Chart 6.3. Organizing approaches to microsocial change with illustrative intervention techniques.

Organization Development (OD). This is a relatively new branch of the applied behavioral sciences. Its methodologies are used to improve organizational functioning by attending to the human side of the enterprise (McGregor, 1960). French and Bell's (1978) definition of OD still rings true:

> A long range effort to improve an organization's problem solving and renewal processes, particularly through a more effective and collaborative management of organizational culture—with special emphasis on the culture of formal work teams—with the assistance of a change agent or catalyst and the use of the theory and technology of applied behavioral science. (p. 14)

In recent years, conceptions of organization development have broadened. For instance, Lippitt (1982) viewed OD as progressing from its earliest emphases on personal growth and group development foci to its newer forms of "human resource development" and "total resource utilization." These expansions have served to concentrate attention on the humanistic use of all individuals in an organization where they are the happiest and, at the same time, the most productive. For the sake of parsimony, I will continue to use the still dominant term organization development, while recognizing that its newer applications embrace total resource utilization as a critical aspect.

As Maynard observed in a special issue of the *Journal for Specialists in Group Work* (1982) on group work and organization development, professional counselors who are well prepared in group theory and skills could become the OD change agent or catalyst in their organizations, adding "OD specialist" to their role descriptions. What are the kinds of direct OD interventions (Burke & Hornstein, 1972; Harrison, 1970; Huse, 1975) that such a counselor—whom I would label a primary preventive counselor—could perform? Five are highlighted in this section: (1) data feedback, (2) training, (3) teambuilding, (4) career development, and (5) process consultation.

Data feedback is involved in nearly any OD project. Organizational members can be surveyed or interviewed to obtain direct information about how the organization is doing and about how they are doing in it. The data that are produced are organized in such a way as to be fed back to those who generated it. Following this data feedback phase, the work group can make decisions about what to do in response to this information. For instance, they might decide to take no action steps, to request additional data, or they might organize into task forces to develop change plans based on the information.

Training is probably the most familiar OD intervention for group specialists (Maynard, 1982). It is premised on the belief that organizations can function more effectively if their individual members learn to work more productively and efficiently. Thus training is frequently provided in organizations to improve employee competencies in such areas as communication skills, conflict resolution, stress reduction, time management, and in task-related skills. In general, the overall effectiveness of this approach is dependent on the existence of a genuine interest of trainees in learning and implementing the training skills, the competence of the trainer, and whether training is the most appropriate way to meet the existing needs of the employees.

Teambuilding is an OD intervention that focuses on intact work groups in an organization, rather than on separate individuals. The intent is to assist these primary work groups to learn the competencies that will allow them to work effectively together. This goal often involves attention being given to problem-solving skills and to interpersonal relationships. The emphasis is on helping members to become better able to resolve the conflicts that inevitably arise in the course of work.

Rapin (1985) illustrated the use of teambuilding well in the initial training program for installing quality circles in the Laundry and Linen department of a University Hospital. Teambuilding sessions addressed members' common work situation (e.g., to identify job-related goals and problems), working together as a group (e.g., through structured communication and feedback exercises), and, finally, how to brainstorm ideas. In such ways, a work team can be strengthened as the members prepare to solve problems and generate creative ideas.

Career development is an OD intervention that recognizes the importance of how personal and immediate work issues interact with the progression of one's career. And for most professionals working in organizations today, career is a central organizing facet of our lives. Organizations have begun to recognize the importance of providing career development assistance to their employees. This assistance takes many forms, from career counseling, to career life planning workshops, to outplacement counseling for those who are laid-off. The premise that an optimal match between a worker and his/her job is desirable for both the individual and the organization has stimulated considerable OD activity in this area.

Process consultation is an OD intevention that is based on principles of direct consultation. Schein (1969) has written the treatise on process consultation. He defined process consultation (PC) as, "a set of activities on the part of the consultant which help the client to perceive, understand, and act upon process events which occur in the client's environment" (p. 9). In PC, the consultant does not prescribe solutions, as one might do in an expert role, but he/she observes a work group in action and helps members to develop their own diagnoses and solutions.

The major areas of activity in PC are found in (1) communications among work members, (2) the functional roles that work members play, (3) problem-solving and decision-making procedures, (4) group norms and growth, and (5) leadership and authority. The intent is for the work group to develop its resources to the extent that it can become self-correcting in the future.

I have used the PC approach frequently with student organizations on university campuses. In one case, colleagues and I trained 200 student organization leaders and members in the skills of PC through didactic information and simulation techniques. We then made ourselves "on-call" as PC consultants to support their use of those skills in their student organizations. I have found the approach to be attractive to the learners and, with support, very usable in their settings.

Process consultation provides a foundation for many other OD interventions. Further, because its competencies are well within the repertoire of most professional counselors and counseling psychologists, PC is an especially important organizing intervention for primary preventive counselors.

Group Task Facilitation. All of the OD interventions previously described involve good competencies in group facilitation. In fact, an excellent case can be made that group facilitation skills comprise the core of OD work.

And yet, the most frequent uses of group facilitation skills are outside of OD—literally, everywhere else. Indeed, as I have shown before (Conyne, 1985), group facilitation skills are broadly and flexibly used to both correct and to enhance personal functioning, in situations that are primarily personal (such as psychotherapy groups) or that are essentially task-focused (such as quality circle groups). Primary preventive counselors would be interested most in uses of group facilitation skills

for personal and task enhancement, rather than correction. In this section on microsocial organizing, the use of group facilitation for task enhancement will be addressed.

These task groups are the most pervasive of our society. They include committees, task forces, staff conferences, retreats, action groups, pot boilers, buzz sessions, meetings, quality circles, and others that are too numerous to mention. As Wilbur, Roberts-Wilbur, and Betz (1981) and Waldo (1985) conceptualized it, the overall objective of task groups is "extra-personal" in nature; that is, it is to accomplish a task, to complete a project, or to produce a tangible outcome.

Executive functioning is used by a task group facilitator to emphasize the functions of control, efficiency, and expediency (Saltmarsh, Jenkins, & Fisher, 1986) in reaching established goals. These functions are essentially managerial in nature. As such, they capitalize on one of the four main functions identified by Lieberman, Yalom, and Miles (1973) as important for good group facilitation: executive functioning. The activities of executive functioning are related to managing tasks. They include limit setting, establishing norms and rules for operation, goal setting, convening, eliciting, channeling, protecting, helping in decision-making, providing performance feedback, mobilizing and using resources for task accomplishment, and developing workable ways to share leadership (Gill & Barry, 1982; Pearson, 1981; Schindler-Rainman, 1981). The facilitator uses these skills of executive functioning to direct the group to its charge, point out interferences to group functioning, move the group to decision-making, and to terminate the group when the task is completed or when time has expired.

Establishing a caring environment also must be paramount for a task group facilitator. Task group members need to develop a basic relationship and interpersonal trust necessary to allow them to work effectively toward realization of their goals. To promote these basic ingredients, the task group facilitator needs to establish a caring environment, one in which the members feel acknowledged, respected, and supported.

Encouraging innovation and risk taking is a third important function. The task group facilitator needs to be able to produce an emotionally stimulating work setting, as well as a caring place. Both challenge and support are necessary to productive working. Accomplishing this blend requires the task group facilitator to successfully match his/her style of facilitation with the readiness level of the group members (Hersey, 1984).

Attributing meaning is a fourth critical aspect of a task group facilitator's functioning. He/she should help members to make sense of their experience and of each others' contributions. This is the function of meaning attribution, and without its presence, group participation is chaotic and pointless. Many task groups fail when their members become confused and unsure of why they are there or what they are supposed to be doing.

In summary, the skills of executive functioning are fundamental for the proper management of task groups. However, these skills are often the ones that are most lacking in the group work curricula of professional counseling and counseling psychology training programs. Primary preventive counselors need to gain these skills of executive functioning to complement their other group skills, which are usually focused on the caring function, so that they can increase their usefulness to the large number of task groups in our society.

Administration. Social policy, as was pointed out in Chapter 5, is a very important vehicle for reaching primary prevention goals. Social policy is difficult to influence or change for counseling practitioners, however, because they usually have no direct control over its creation and management.

One of the chief ways for gaining greater control is for the counseling professional to *assume an administrative position* (Reppucci & Sarason, 1979). In such assignments, the capacity to shape and implement social policy that is in line with the promotion of both human and organizational health becomes at least theoretically possible.

The administrative role exemplifies a direct method in primary preventive counseling, whether or not face-to-face contact with the target is maintained, because policy matters are more-or-less under the control of the administrator. Administrators of educational, health, and staff resource programs, who may be called "human resource managers," are in especially opportune positions to guide institutions in humane and productive directions.

I chose to pursue this route during the last six years at the University of Cincinnati, precisely for this reason. As Associate Vice Provost for Student Life I found it occasionally possible to put into policy what good theory and research suggests should be in place.

For instance, we developed and implemented, with full participation by student, faculty, and staff representatives, a campus alcohol policy that was structured around choice and responsibility in drinking practices (Conyne, 1984). And, again with collaboration, we sought to eliminate the dehumanizing practice of hazing through policy and educational efforts. Both of these efforts were based on primary prevention concepts and methods.

At the same time, the daily burdens that every administrator must face sometimes can seem to overwhelm any effort to advocate informed and consistent change from within. Yet the potential for conducting primary preventive activities through administration is worth considering by more counseling professionals.

Skill Development

Organizing approaches to skill development are a vital part of competency enhancement. The organizing approaches are based entirely on group facilitation. Therefore, their use by counseling practitioners, who normally are well-trained in this domain, can be expected to both frequent and of high quality.

Helping Groups. The helping group provides a powerful resource and refuge for personal change. That is, when working properly, the helping group allows members to grow and to challenge each other in an atmosphere of safety and security.

These helping groups offer a number of "therapeutic factors," the ingredients that are thought to cause these groups to be promoters of personal change (Yalom, 1985). The 11 therapeutic factors are as follows:

1. *Instillation of hope:* If other members can change, I can, also.
2. *Universality:* All of us have our problems.
3. *Imparting of information:* Members learn different approaches and ideas.
4. *Altruism:* I can help other groups members.

5. *Corrective recapitulation of the primary family group:* I can relive and redo some of my family relationships in the group.

6. *Development of socializing techniques:* I can develop better social skills.

7. *Imitative behavior:* I can learn through observing what other members and the facilitator do.

8. *Interpersonal learning:* This group represents social reality as a microcosm.

9. *Group cohesiveness:* We accept each other.

10. *Catharsis:* I can freely express my emotions.

11. *Existential factors:* Despite life's problems, I am responsible for my life.

Although many of these curative factors are to some degree or other important for any kind of group to function well, they all are important for helping groups. These factors become interwoven in the ongoing fabric of a helping group's life, enabling the members to advance their own—and each other's—personal and interpersonal competencies.

The group facilitator has the task to be a weaver of the group fabric, as well as to help members to apply learned competencies both in the present and—importantly for primary prevention—in the future. As Lieberman et al., 1973, stated it:

> The leader's function is to prevent any potential obstruction of the evolution of the intensive experience, and in addition to be the spokesman (sic) for tomorrow as he encourages group members to reflect on their experiences and to package them cognitively so that they can be transported in the future. (p. 439)

The helping group facilitator accomplishes these ends through seeking to employ a desirable blend of group leader functions. As you saw with regard to task group facilitation, the most salient group leader function was executive function, although all were important. By contrast, in helping groups, the most effective blend of functions has been found to include (1) high amounts of Caring, (2) high amounts of Meaning Attribution, (3) moderate amounts of Executive Function, and (4) moderate amounts of Emotional Stimulation.

According to Lieberman et al. (1973), this blend yields the most successful type of helping group facilitator, which they termed the *"Provider."* Apparently, the provider is the one who can best establish a warm and cohesive environment (Caring); who can best challenge and stimulate learning (Emotional Stimulation); who can best weave group interaction toward goal production (Executive Function); and who can best help members relate present learnings to future behavior and situations (Meaning Attribution).

The kinds of helping groups that are available for use today (e.g., see Conyne, 1985) are far too numerous to cite here. As a sample, they include groups for psychotherapy, personal growth, counseling, and interpersonal skills. One type of helping group holds particular merit for primary prevention. This is the thematic, structured group experience. Chart 6.4 contains the helping group as the main organizing approach for skill development, as well as several intervention techniques. One technique, the thematic, structured group is discussed briefly in the next several paragraphs.

Organizing Approach	Sample Intervention Techniques
Helping groups	Personal growth Interpersonal skills Thematic, structured groups

Chart 6.4. Organizing approach to skill development in competency enhancement with illustrative intervention techniques.

Thematic, structured groups are helping groups that maintain a relatively specific focus and employ gradients of structure in their format. They are not the loose, open-ended personal growth group nor, however, are they rigidly mechanistic.

Thematic, structured groups are focused, that is, they center on one major issue of importance to members. This issue might be stress

management, becoming assertive, conflict resolution, or study skills development, among others.

As mentioned, this type of helping group includes elements of structure, rather than being completely open-ended. That is, the group facilitator introduces a flexible set of planned experiences that are timed to the developing pattern of the members, as well as the group, in order to maximize the efficiency and effectiveness of learning.

The proper use of this kind of structuring demands that the facilitator possess good knowledge of how individuals and groups develop (e.g., Anderson's, 1984, "TACIT" model of Trust, Autonomy, Closeness, Interdependence, and Termination), so that an appropriate group plan can be devised. Then, in addition to other basic group facilitator skills, it requires that the facilitator use sensitivity and flexibility in applying this well-conceived plan. For instance, knowing when to "junk" the planned exercises for a session and to "go with the flow" of the group is critical to group effectiveness.

The basic model for this type of helping group was developed by Cohn (1969, 1972), whose theme-centered interaction method has been adapted to a wide variety of targets and purposes. While this group technology is used frequently to correct problem behavior, its potential for primary prevention is exciting. For instance, Drum (1985) has applied it for preventive purposes with university students, Clack (1985) has adapted it to teach human relations skills in business and industry, and Gazda (e.g., Gazda & Pistole, 1986) has proposed a group-based program he calls "Life Skills Training" (focused on interpersonal communication, problem solving, physical fitness, and identity development) to serve as an organizing framework for preventive services in a range of settings.

An extensive resource of structured exercises has been developed over the years. Many of these structured exercises can be used in groups for primary prevention. For example (Pfeiffer & Goodstein, 1986), over 400 structured exercises have been described in terms of their goals, methods, and time and materials required. In addition, these structured exercises have been graded with regard to their degree of complexity and the amount of processing they could be expected to require. This kind of resource information provides prospective group facilitators with much needed guidance for what structured experiences might be appropriate to their particular situation.

Many of my students have drawn from this set of resources, and others (e.g., Tubesing & Tubesing, 1984a, b), to create and deliver thematic, structured groups that have addressed primary prevention goals. These have included aiding groups of recently retired nuns to plan their immediate futures, helping single parents learn time management techniques, teaching new students campus survival skills, showing hall residents methods for gaining greater personal control and privacy, helping religious educators to reduce their stress levels, and aiding the recently widowed to mobilize their energies to become actively re-involved in their communities.

The basic technology of thematic, structured groups meshes well with the pursuit of primary prevention goals. Primary preventive counselors will want to be sure to include it as a major weapon in their arsenal of organizing interventions.

SUMMARY

Organizing is the second major direct method for primary preventive counseling. Six approaches of organizing were presented in this chapter: (1) community development, (2) social and political action, (3) organization development, (4) task group facilitation, (5) administration, and (6) helping groups.

When implemented before-the-fact, the organizing approaches provide especially powerful means for primary preventive counseling. This is so because organizing, by definition, is targeted at groups, organizations, and communities—the natural turf of primary prevention. Also these approaches are potent because group skills are a fundamental part of any professional counselor's helping repertoire.

ISSUES FOR REFLECTION AND DISCUSSION

1. Education, the focus of the previous chapter, and organizing, the focus of this chapter, each possesses relative strengths for primary preventive counseling. What are these strengths? Try discussing the relative merits of each approach with a partner.

2. Organizing offers six approaches for primary preventive counseling to be conducted: community development, social and political action, organization development, task group facilitation, administration, and helping groups. Summarize each of these approaches. Which do you find the most appealing? Why?

3. Within system change, two approaches exist: community development and social/political action: Describe the differences in their basic assumptions. Which of the two approaches do you find more attractive? Why?

4. Organizing approaches for microsocial change in primary preventive counseling include organization development, task group facilitation, and administration. Describe each one. Select one approach and design your own illustration of how it could be used in primary preventive counseling.

5. Eleven "therapeutic factors" are integral to helping groups. What are five of these therapeutic factors and why are they so important?

6. What combination of group facilitation functions has been found to be most useful in helping groups? What is this type of group facilitation termed?

7. Thematic, structured groups hold the most potential of all helping groups for primary preventive counseling. What are these groups and why are they so potentially helpful?

8. Assume that you will be talking with an educational organization about a possible OD project that you, as a primary preventive counselor, might conduct. What kinds of OD interventions might you discuss as being possible, based on your reading of this chapter? How would you present your proposal?

HIGHLY RECOMMENDED SUPPLEMENTARY READINGS

Conyne, R. (Ed.). (1985). *The group workers' handbook: Varieties of group experience.* Springfield, IL: Thomas

This book is structured around a "group work grid." This grid provides a useful framework for understanding the diverse world of group work, from groups that are corrective or enhancement in purpose to those that are personally or task-oriented. Groups are also organized by their level of intervention. The book chapters focusing on enhancement at the organizational level are of considerable interest for the organizing approach in primary preventive counseling.

Huse, E. (1975). *Organization development and change.* St. Paul, MN: West.

An excellent source on organization development and change approaches, this book is organized to clearly address the major methods of OD, ranging from broad, macro approaches to the intensely personal. Examples included at the end of the book are especially illuminating.

Lieberman, M., Yalom, I., & Miles, M. (1973). *Encounter groups: First facts.* New York: Basic Books.

This report of an extensive research study of the effectiveness of a number of distinct encounter group approaches yielded a substantial base of information about group leadership, group casualties, and the importance of group membership on outcomes.

Maynard, P. (Special Editor). (1982). Group work and organization development. *Journal for Specialists in Group Work, 7* (Whole No.)

This special issue of the journal focuses on the relationship between group work and organization development. Readers should gain an appreciation for how important group work competencies are for conducting most OD interventions.

Stone, G. (1986). *Counseling psychology: Perspectives and functions.* Monterey, CA: Brooks/Cole.

This book structures counseling psychology into several main functions, including guiding, healing, facilitating, modifying, restructuring, developing, communicating, and organizing. The last function, organizing, is especially useful for its relationship to organizing in primary preventive counseling.

Yalom, I. (1985). *The theory and practice of group psychotherapy* (3rd. ed.). New York: Basic Books.

This book is probably the classic in the field of group psychotherapy. Now in its third edition, it is known not only for its contributions to both theory and practice but, also, for its attractive writing style.

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CHAPTER 7

CONSULTATION: AN INDIRECT METHOD

While the direct methods of education and organizing are used in a face-to-face way with a target, the indirect methods of consultation and media are applied through another party or system to reach a target. In the case of consultation, the subject of this chapter, the intermediary is called a consultee, such as the teacher who is concerned about his/her student. With regard to the media, the focus of Chapter 8, the intermediary consists of radio, television, pamphlets, computers, and other forms of media that are used to present a desired message to the target audience.

Throughout most of the history of counseling psychology, clinical psychology, professional counseling, and other helping services, no need existed to discuss "direct" methods as opposed to "indirect" ones. Only direct methods, such as individual counseling and psychotherapy, existed for use.

However, conditions changed. Indirect methods emerged to complement the direct methods, largely in recognition of the need to extend the reach of professionals. As you read in Chapter 1, the demand for educational and psychological services far exceeds the supply of competent and available professional counselors and counseling psychologists. Further, even when setting aside this reality for a moment, the realization that the matching of a professional counselor or counseling psychologist with an individual requiring help is not always the most effective way to proceed.

Sometimes more appropriate help can be found through consulting with indigenous helpers or through the formation of a support group.

Thus, a necessary step in contemporary counseling is to differentiate between both direct and indirect methods. Certainly this is the case in primary preventive counseling, where the indirect methods are so useful.

CONSULTATION IS A KEY INDIRECT METHOD

Rev. Johnson has a challenging situation on his hands. The church's congregation is growing by leaps and bounds, so much so that space for the two worship services is at a premium. At the same time, participation on church committees is lagging. He thinks that getting some outside expert assistance may be needed to help solve these issues.

By all accounts, Tommy is a hellion in his third grade class. He may be redefining the label of "acting-out." His teacher, Ms. Samuels, is wondering how she can better handle not only Tommy, but, also, the total classroom environment which has been disrupted.

Dr. Robbins, a counseling psychologist who consults frequently with organizations, was contacted by Bill Turbin, the President of Buildem, a family-owned construction business in town. The company, he reports, is doing exceptionally well, having generated $20 million in sales last year. In fact, its successful growth led to his call: Turbin requests help in developing a plan for growth in the organization so that control and direction become predictable rather than a surprise.

Carlos Lopez is Vice President for Student Affairs at the local college. Through what he and his staff have learned informally from talking with students and from survey research they have conducted, the campus is perceived by many students as being an unfriendly place. In fact, too many of them report never feeling "at home" there and a high percentage of those students are transferring to other schools because of it. Lopez plans to seek external consultation from a campus ecology expert to help the college better address this situation, so that a "staying environment" might be created on campus.

Shirley Williams is a counselor at the Senior Citizens Center. She has noticed an increasing number of recently widowed women seeking in-

dividual counseling. She learns from several of them that talking with others who have been recently widowed would be helpful. In response, Shirley decides to initiate a support group. Not being sure how to best go about this, she turns to a local expert for consultation.

Each of these examples illustrates common situations where consultation is requested, as well as how it can be potentially useful. You can easily see how one professional counselor, by consulting with others, can greatly extend his/her impact: A church's functioning could be improved, a student and the classroom can be stabilized through enhanced teacher practices, a company can institute procedures to ensure even greater success, the environment of a college can become more student-centered, and widows can be led to aid one another while helping themselves at the same time. By using consultation, the professional counselor works through others—*consultees*—in helping them to accomplish their work-related goals.

DEFINITION OF CONSULTATION

Implicit in the examples above are aspects of what consultation is. Basically, *consultation is a triadic process in which a professional expert assists a consultee—a person, group, organization, or larger system—to mobilize resources to better handle a target situation of concern* (Brown & Kurpius, 1985; Curtis & Zins, 1981; Gallessich, 1982, 1985; Kurpius, 1985; Kurpius & Brubaker, 1976; Lippitt & Lippitt, 1978). Take the example of Tommy and Ms. Samuels, previously provided. The guidance counselor or school psychologist contacted by Ms. Samuels assumes the role of consultant to her about Tommy and the classroom situation. Ms. Samuels, the consultee, learns strategies to use in helping Tommy to behave more appropriately and, in turn, for improving the classroom environment.

Observe the triadic nature of this helping process. The consultant ("A"), works with the consultee ("B"), to help the consultee become more effective in working with the client or target ("C"). This triadic process exemplifies the indirect aspect of consultation. Note, also, the work focus of consultation. Any personal problems of the consultee that are not work-related are outside the scope of consultation. The clear emphasis is upon helping the consultee become more proficient in his/her work.

Other elements characterize consultation, as well. It is based on an open, trusting working relationship that is voluntarily assumed, requires the active participation of the consultee, and it is confidentially maintained. Very importantly, consultation always accepts dual purposes: to correct any pertinent work problems and to increase the consultee's competencies so that similar future difficulties can be prevented (Gutkin & Curtis, 1982). Two features of consultation are especially amenable for primary preventive counseling: (1) Its indirect process, as mentioned, multiplies the effect that one professional counselor can bring to a helping situation; and (2) one of its purposes is always preventive, regardless of the presenting situation.

MODELS OF CONSULTATION

A number of theorists and researchers have identified different models of consultation. For example, Gallessich (1985) has conceptualized three new configurations of consultation, which she termed: (1) *scientific-technological,* where the consultant functions primarily as a technological or clinical expert; (2) *human-development,* where the consultant's role is that of an educator or facilitator; and (3) *social/political* consultation, where the consultant is a partisan advocate for change.

In a second example, Kurpius and Brubaker (1976) have offered a generic view of consultation modes which they labeled: (1) *provision,* where the consultant provides expert services such as training or clinical services; (2) *prescription,* where the consultant diagnoses and prescribes a course of action; (3) *mediation,* where the consultant acts as the coordinator, manager, or designer of a treatment program delivered by other professionals; and (4) *collaboration,* where the consultant facilitates consultee action in problem solving and action.

A third frequently cited perspective, especially among counseling, school, and clinical psychologists, is Caplan's (1970) mental health consultation. He described four types: (1) *client-centered case,* where the consultant aids a consultee's understanding of a client to improve service to that client; (2) *consultee-centered case,* where the consultant seeks to advance the knowledge and skills of the consultee so that the consultee's present and future work can become more effective; (3) *program-centered administrative,* where the consultant provides planning and administrative help in order for an organization to develop a new program or improve an existing one; and (4) *consultee-centered administrative,*

where the consultant focuses on the organization itself, attempting to improve its overall functioning.

Other important models for understanding consultation exist, also, such as Blake and Mouton's (1976) "consulcube," which organizes consultation into 100 different forms based on the kind of intervention, the unit of intervention, and the focal issue being addressed. For the sake of brevity, however, the models of consultation as identified by Gallessich (1982) will be presented in an effort to provide a basic grounding. These models are (1) education and training, (2) clinical consultant, (3) mental health, (4) behavioral, (5) organizational, and (6) program.

Model 1: Education and Training

This is the most basic form of consultation. Information or technical assistance is disseminated or taught to the consultee or consultee system. The premise is that the consultee can master this information and apply it appropriately with clients. In this manner, one consultee or, as is often the case, a group of consultees, are the information recipients.

The consultant as educator or trainer is an economical model for dispensing useful material to consultees. How that material is used is solely the responsibility of the consultee. An example of this model can be found when a teaching staff (the consultees) engages a professional counselor (consultant) to update their knowledge about drug and alcohol abuse prevention through a two-hour workshop.

Model 2: Clinical

This approach, identified by Caplan (1970) as client-centered case consultation, involves the professional counselor as one who provides expert clinical diagnosis and recommendations to a professional helper about a particular case. For instance, a professional counselor is contracted by an alcoholism center to consult about psychological issues involved in the alcoholic behavior of those clients whose cases are presented for review.

Model 3: Mental Health

In this model, which Caplan (1970) termed consultee-centered consultation, the knowledge and skills of the consultees themselves become

the focus of attention. Here, the "spread of effect" concept is critically important. That is, the professional counselor, through consultation, enables the consultee to gain greater competencies so that, in turn, the consultee becomes better able to help his/her clients. This model has been used to help members of police departments learn crisis intervention skills which they can use in the future to resolve citizen disputes more effectively. In a similar fashion, Forti (1983) described how mental health consultation was successfully conducted with a religious administrative group that anticipated future organizational turmoil. Study of the "spread of effect" of this consultation two and four years later showed significant increases in support and well being, with lowered anxiety levels throughout the organization. The primary prevention goal of strength-building to avoid organizational disturbance was met. The clear goal in this model is to "give psychology away" so that consultees can become effective primary preventive agents in the settings in which they live and work.

Model 4: Behavioral

This model also embraces the "spread of effect" concept that is central to mental health consultation. However, it is based exclusively on learning theory. As dysfunctional behavior is assumed to be learned, it therefore can be unlearned through the application of empirically derived learning principles.

This form of consultation tends to be directive, involved with observable behavior, and focused on environmental constraints. Professional counselors who consult using this model frequently find themselves working in settings where client conformity to rules and procedures is important, such as in correctional institutions, hospitals, and certain schools. It is also used for preventive purposes. For instance, in a study by Spitzzeri and Jason (1979), ninth-grade students role-played sketches showing common encounters with smoking and they were taught specific assertive ways to resist peer pressure to smoke. Results revealed that two-thirds of the smokers had stopped, and no nonsmokers had begun smoking during the program or at a three-month follow-up.

Model 5: Organizational

In this model, the workplace itself—its environmental design and function--assumes the focus of attention. Most of us are aware that

work settings are dominant aspects of peoples' lives, and that they are frequently the source of much dissatisfaction. The relationship of people with each other and with work tasks, is one especially ripe area for organizational consultation today. A second growing area is that of technostructural change, which is concerned primarily with how work tasks and organizational structure are established and function. As Weisbord (1978) has shown, organizational factors of consultative importance include the organization's purposes, the staff relationships, the structure of the organization, how leadership gets implemented, the effectiveness of its helpful coordinating mechanisms (e.g., planning, budgeting, technology), the reward or incentive system that operates, and the relationship of the organization with its external environment. Consultation to improve the effectiveness of a wide variety of organizations—human service, corporate, educational, health care, religious, governmental, and small businesses of many kinds—is an emerging role of importance for primary preventive counselors.

Model 6: Program

This model of consultation is similar to Caplan's (1970) program centered administrative consultation. The emphasis is on one discrete program of an organization, with consultation used to assist in its development or improvement. Essential consultant competencies in this model involve action research, program development and program evaluation. As an example of program consultation, I was recently contracted by a university's counseling department to evaluate the relationship of one its programs, Human Services Education, to an ideal model. I examined the program's written documents, especially the curriculum, and interviewed a number of faculty and students in this process. I then compared these findings with existing standards for such programs, and submitted an evaluation report, with recommendations for improvement that are now being considered by an action committee.

THE PROCESS OF CONSULTATION

While a number of models exist to describe consultation, a generally common understanding exists about how consultation proceeds, that is, about the consultation process (Lippitt & Lippitt, 1978). Regardless of consultation model, the process according to Kirby (1985) includes three generic phases: (1) *facilitative*, where consultees become actively involved through establishing a working relationship, task commitment,

and problem clarification; (2) *directive,* where problem-solving occurs by exploring alternatives, forming action plans, and in stabilizing the plan through trial and feedback; and (3) *termination,* where learnings are consolidated, future plans are made, and the consultation is concluded. This process in summarized in Chart 7.1.

PHASE I: FACILITATIVE

Stage 1: Initial (Definition & Awareness)

Stage 2: Tentative Task Commitment

Stage 3: Problem Clarification

PHASE II: DIRECTIVE

Stage 4: Alternative Exploration

Stage 5: Action

Stage 6: Stabilization

PHASE III: TERMINATION

Stage 7: Projection/Termination

Chart 7.1. Phases and stages of the consultation process (Kirby, 1985).

With phases and stages of the consultation process as background, let us now move to examine how consultative interventions can be used to seek system change and person change in primary prevention. Parsimony is a paramount need in this discussion, given space requirements in relation to the wealth of material available. Please refer to the sources cited for in-depth coverage.

CONSULTATION INTERVENTIONS IN SYSTEM CHANGE

Heller (1985) made the point that consultative interventions at the community level are basically the same as those available for use at other levels. The more important distinctions for him are realizing how community change occurs, what its impediments are, and that such change—when it is able to happen—comes in small doses.

With Heller's observation well in mind, three consultative interventions can be identified that are particularly well-suited to fostering community or system change. These are (1) mediation, (2) network/coalition building, and (3) advocacy. They are presented in Chart 7.2, followed by a short description of each.

SYSTEM CHANGE INTERVENTIONS	WITH
Mediation	Social regulators
	Conflicting parties
Network/Coalition Building	Indigenous community members
	Professional helpers
Advocacy	Individuals with similar values

Chart 7.2. System change consultation interventions and illustrative person with whom used.

Mediation

Frequently, when system change issues, such as poverty, racism, and unemployment are being struggled with, conflicts emerge between competing groups. For instance, Heller (1985) has described the conflicts that can occur between an indigenous community group that is pressing for a system change to improve interracial tensions in a community and what he termed the "social regulators"—those institutional organs, such as city government and corporations—that can be conceptualized as primary prevention opportunities to advance social justice.

Consultants can be successful in these kinds of situations. Sometimes they have functioned as mediators between the conflicting parties, helping to maintain communication and to facilitate movement toward joint decision-making. For instance, colleagues and I have stepped in on a university campus to mediate a potentially explosive interracial conflict between White and Black students about the possible elimination of "duplicate" Black student organizations. Mediation of this crisis has led subsequently to the collaborative development of a primary preventive Racial Awareness Program at the university.

Network/Coalition Building

This consultation intervention is used to produce community empowerment (Maguire, 1983) or, as Iscoe (1974) called it, the "competent community." While this intervention can take place at several levels, basically two exist: (1) indigenous community members who share a common concern but who are frequently scattered and unaware of each other's concerns and resources; or (2) professional helpers who share similar attributes (Heller, 1985; Ketterer, Bader, & Levy, 1980; Maguire, 1983).

One standard means for network/coalition building by a consultant is to bring these individuals together in a combined task force to begin sharing information, resources, and concerns. For instance, I have organized such a network task force of service providers on a university campus to focus on the unaddressed issue of commuter student involvement in the institution. In a second case of community empowerment, human service agencies in many of our cities are networking to pool their resources to improve the quality of life for the poor. The "Cincinnati Collaboration," for example, comprised of 52 human service agency representatives, has organized to identify system oppression and to cut

through it. Its strategy is to open up access to resources such as money, land, education, technology and employment, and to aid the poor in gaining greater control over them.

Other issues for which this approach has been used include drug abuse prevention, interracial awareness, domestic violence prevention, children's issues, sheltering the homeless, and others. See Cunningham and Kotler (1983) for a list of 14 organizational steps for building such a networking system.

Advocacy

A fine line exists between consultation and advocacy according to Gallessich (1982). For her, advocates are advocates and consultants are consultants, and "never the twain do meet." However, consultants who clearly express a particular value system do get hired by consultees who share similar values. In such situations, as when a feminist consultant is hired by a city government wishing to design and implement a sexual harrassment plan, a kind of advocacy consultation can occur. In other cases, a consultant who discovers that his/her values differ substantially from those of the consultee, such that the consultation is harmed, should openly discuss these differences in order to seek an acceptable accord of some kind or, failing that, to terminate the working relationship.

CONSULTATION INTERVENTIONS IN PERSON CHANGE: COMPETENCY ENHANCEMENT

Microsocial Change

The main consultee in microsocial change is the organization. Thus, in terms of the consultation models identified earlier in this chapter, Models 3, Mental Health; 5, Organization; and 6, Program Consultation are most directly relevant. These three models include a number of indirect methods for organizational improvement, of which three are summarized in this section; (1) technostructural approaches; (2) action research; and (3) environmental design. These microsocial consultation interventions are contained in Chart 7.3.

COMPETENCY ENHANCEMENT INTERNVENTIONS	METHODS
Microsocial	Technostructural approaches Action research Environmental design
Skill Development	Case consultation Education and training Support group consultation

Chart 7.3. Consultation interventions and illustrative methods for competency enhancement.

Technostructural Approaches. These approaches are used to simultaneously change both task methods and task assignments in an organization (Goodstein, 1978). That is, the focus for change is on both the technology used and the structure in place within the organization. Therefore, what work is done, how it gets done, how the work setting is organized to produce work, and how effectively employees work together are all immediately pertinent for technostructural change. Here, the emphasis is not on human processes and interrelationships, with work as an interrelated, but secondary interest. Rather, the principal focus in technostructural approaches is on work and its concomitants.

Consultants trained as professional counselors and counseling psychologists naturally turn to personal and interpersonal processes in their work. Technostructural approaches, which emphasize work, technology, and organizational structure in relation to human processes, tend to be used less often due to their relative unfamiliarity. Primary preventive counselors can benefit in their consultation by becoming aware of the major technostructural interventions of sociotechnical change, job redesign and job enlargement, and job enrichment (Friedlander & Brown, 1974). Porras and Berg (1978) suggested, for example, that the inclusion of such task-related interventions in consultation can strengthen its effects.

Action Research. The wise words of Kurt Lewin (1951) "No action without research and no research without action," gave rise to action research. A central task of any consultant is to assist the consultee to better understand the present situation through the review of the best available information. A corollary task is to assist the consultee to use this information to make decisions about what, if any, action to take and to subject any action taken to regular evaluation.

As Price and Politser (1980) viewed action research, it possesses four generic characteristics. First, action research has a distinct problem focus, such as how to increase the coping skills of children or how to foster a positive work climate in an organization. Second, it involves collaboration between the action researcher and practitioners, allowing the often "ivory tower" world of research to be concretely informed by the "nitty-gritty" world of practitioners in the trenches (and vice-versa). Third, action research is used to develop scientific and practical knowledge, so that, as Conyne and Clack (1981) stated, "Results generated are used by the client system and they are also meant to contribute to the public and scientific storehouse of knowledge" (p. 96). Fourth, Price and Politser emphasized that action research is characterized by a commitment to research utilization, so that the word gets out to wider circles of researchers and practitioners. These generic characteristics of action research accord it a valuable place in consultation for microsocial change.

Environmental Design. Chapter 3 contained descriptions of some of the environmental interventions that constitute an emerging and important form of action in professional counseling and counseling psychology. Environmental design (e.g., Conyne, 1985; Conyne & Clack, 1981; Huebner & Corazzini, 1984), is a center-piece of this type of involvement.

The focus of environmental design is to create or redesign human environments, such that they will foster and support growth, development, and effective functioning. The environmental design process is rooted very closely in the precepts of action research, previously described. It incorporates steps of data collection, user participation, continual feedback, program development, the institution of environmental change, and reassessment.

This environmental design process has been used to seek both system change and person change. In person change, environmental

design seems most effective when applied at the microsocial level of competency enhancement. For instance, the Resident Environment Adaptation Program, or REAP (Daher, Corazzini, & McKinnon, 1977), has been employed in various ways to offer university student living groups a sound opportunity to adapt their housing environment to their living and learning needs. Guided by the environmental design steps mentioned above, residents have reshaped various facets of their house environments, including quiet hours and wall painting policies.

In another example of a microsocial project, Von Holle (1986) studied the social environments of 18 fraternity houses on a university campus in relation to the drinking behavior of their members. He concluded that certain fraternity house social ecologies may contribute differently to either high or low drinking behavior. For instance, houses with high levels of academic achievement, involvement, and student influence were those registering the lowest amounts of drinking alcohol.

Based on this finding, Von Holle recommended several environmental interventions to support academic achievement as a primary preventive measure to maximize responsible drinking. These included establishment of a daily quiet time for study room with adequate facilities. In keeping with the person-by-environment base upon which environmental design is established, he also recommended several person-level interventions. These included encouraging the use of tutors and in-house study groups, and sponsoring awards for each house that highlight members' academic achievements. Follow-up consultation to assist in these recommendations is occurring.

Environmental design, at its heart, is a consultative process. Lack of knowledge and skill in consultation dooms to failure this otherwise fruitful approach to primary prevention. This provides yet another reason for why primary preventive counselors would do well to become proficient consultants.

Skill Development

Consultation can be applied specifically to increase the competencies of individuals, whether these be consultees or clients. The salient consultation models (Gallessich, 1982) involved are educational, clinical, and behavioral; together, these models contain many skill development interventions. Three of the major forms—(1) case consultation, (2)

education and training, and (3) support group consultation—are presented in Chart 7.3, and a brief description of each follows.

Case Consultation. Caplan (1970) defined this important form of consultation, which has two branches. Case consultation can focus on either: (1) the consultee, which is called "consultee-centered" case consultation; or (2) the client, which is called "client-centered" case consultation.

The purpose of case consultation is to enhance the competency, that is, the knowledge, attitude, and/or the skills, of the consultation target—whether that be the consultee or the client. Case consultation is essentially an individual approach, as opposed to being focused on a group, organization, or system (Fuqua & Newman, 1985).

Consultee-centered case consultation is especially amenable to skill development in primary prevention, because the consultee can gain tools to use not only for present but, also, for future use. For instance, a teacher-consultee may experience much difficulty in handling classroom situations that involve conflict. A consultant can help this teacher gain the necessary self-confidence to better handle these situations by using the basic skills of counseling and psychotherapy: establishing a good working relationship, listening actively, providing effective feedback, facilitating problem-solving and decision-making, and evidencing what Goodstein (1978) called a "superb sense of timing" (p. 26).

Education and Training. This model of consultation can be particularly useful in skill development when the consultee's knowledge or skill in a defined area such as in cross-cultural counseling or in designing program evaluations, is deficient or undeveloped. The consultant can aid the consultee to identify the deficit (or goal), determine its scope, identify the issues pertinent to education and training in this area (e.g., time and cost), consider alternate resources for aid and their availability (e.g., information or training), develop a plan to obtain the chosen resources, and create an evaluation plan. While the consultant might, at times, provide the education or training directly, consistent with the indirect method it would be more likely for her to help the consultee to identify and use appropriate external resources (Fuqua & Newman, 1985). However accomplished, education and training can be the most economical model of consultation for enhancing the specific competencies of a consultee in handling present, as well as future demands.

Support Group Consultation. Support groups are a form of self-help. Community members come together in them in order to give and receive mutual aid (Gartner & Riessman, 1981; Maguire, 1983; Silverman, 1985). Some examples of support groups include Mended Hearts, Widow-to-Widow, Alcoholics Anonymous, the Cured Cancer Club, and support groups for students and trainees. The spontaneous commitment and helpfulness that is generated in these support groups have proven to be of immense personal benefit to countless thousands of individuals across the country.

The role of the professional in relation to these groups is quixotic. Professional expertise and peer motivation are frequently at odds. This conflict results from a frequent mistrust of professionals, on the one hand, or from a refusal to acknowledge the natural sagacity and strength of community members, on the other. However, at times consultants have been able to become meaningfully connected with support groups, thus successfully employing their expertise to benefit members, as Cohen (1983) showed in his work with support groups for medical students. When this occurs, it is a highly efficient use of professional resources.

"Playing the expert" has not been a useful model for professionals in working with support groups. However, consultative and linking modes have been found to be most acceptable and helpful to support groups members. The emphasis in consultation and linkage is on putting interested people in touch with each other, on mobilizing external community resources to help these groups, and on strengthening the internal functioning of these groups by facilitating their group process.

This kind of professional consultation can be expertise-based, practical, and pragmatic. For instance, in terms of the former, Silverman (1985) has identified the salient skills necessary for providing an orientation program for new support group members. These skills include showing sensitivity to others, caring, listening, asking questions, information sharing, and group skills. As well, concrete skills and activities are frequently required of the consultant. Among those that Maguire (1983) listed are finding a meeting place, providing information about resources, making coffee available, and educating other professionals about the good work done by support groups.

CONSULTATION AND PRIMARY PREVENTION

A word of caution. Too many professionals mistakenly equate consultation of any kind with primary prevention. Of course, they are not the same. Consultation is a major approach to use in accomplishing primary preventive goals. Said in another way, consultation is a *means* while primary prevention is a *goal.*

The reason that mistake is made so often may be because primary prevention is only partially understood and because consultation is especially tailored to reaching primary prevention goals. As a colleague and I observed many years ago with reference to the concept of meta-interventions in consultation (Conyne & Clack, 1975)

> ...there are assumed interventions and meta-interventions in consultation (Bennis, 1962)...greater impact becomes possible as intervention moves from person-centered reactive consultation toward system-centered proactive consultation. Meta-intervention facilitates positive system change, thereby affecting the lives of large numbers of people influenced by the system...any consultation can be seen as representing a potential for meta-change. (p. 416)

Consultation becomes a primary prevention approach when it more closely approximates a meta-intervention, that is, when it tends toward being proactive, group-oriented, and system-centered. Indeed, when these demanding criteria are satisfied, consultation is a most potent approach to primary prevention, one that primary preventive counselors need to master.

SUMMARY

An important indirect intervention in primary preventive counseling was presented in this chapter—consultation. It was defined as, "a triadic process in which a professional counselor assists a consultee—a person, group, organization, or larger system—to mobilize resources to better handle a target situation or concern." Six consultation models of education and training, clinical, mental health, behavioral, organizational, and program were defined, and a generic consultation process were presented.

Then, consultative interventions were examined in relation to producing *system change* (mediation, networking/coalition building, ad-

vocacy), and for competency enhancement in *person change* (microsocial: technostructural approaches, action research, and environmental design; skill development: case consultation, education and training, and support groups). Finally, a distinction was made between consultation and primary prevention, presenting the concept of meta-intervention in consultation.

In Chapter 8 will be addressed the use of media in primary preventive counseling. It will complete the indirect interventions, as well as Section II on primary preventive counseling interventions.

ISSUES FOR REFLECTION AND DISCUSSION

1. Consultation was presented as a triadic process. Explain what this means and given an example.

2. What is the difference between a "consultee" and a "client" in consultation? Provide an illustration of consultation where you highlight the difference.

3. Six models of consultation were described. Identify these and pick three that you find especially attractive. Why did you pick the ones you did?

4. A generic process model for consultation was presented that included facilitative, directive, and terminating phases (Kirby, 1985). Identify the stages included in these three phases. Relate this process model to any of the six consultation models referred to in question 3.

5. With regard to consultation for *system* change, mediation, networking/coalition building, and advocacy were discussed. Define and generate one example for each one.

6. In consultation for competency enhancement in *person* change, the microsocial interventions discussed were the technostructural approach, action research, and environmental design. Define and given an illustration of them.

7. Still considering consultation for competency enhancement *person* change, the skill development interventions discussed were case consultation, education and training, and support group consultation. Again, define and provide an example of each intervention.

8. For many ill-advised professionals, consultation and primary prevention are considered to be the same thing. Explain why they are different. Use the concept of "meta-intervention" to assist in your explanation.

9. Pick any consultation model, and any consultation intervention that fits that model. Using the generic consultation process, construct an example of consultation that clearly illustrates is triadic nature.

HIGHLY RECOMMENDED SUPPLEMENTARY READINGS

Blake, R., Mouton, J. (1976). *Consultation.* Reading, MA: Addison-Wesley.

This book is notable for its "Consulcube," which organizes consultation into combinations of three dimensions: Kinds of interventions, Units of change, and Focal issues.

Brown, D., & Kurpius, D. (Guest Editors). (1985). Consultation. *The Counseling Psychologist, 13.* Beverly Hills, CA: Sage, Whole Issue.

This recent special issue of the publication is focused on four aspects of consultation: Meta-theory, interventions, preservice training and supervision, and ethics.

Caplan, G. (1970). *The theory and practice of mental health consultation.* New York: Basic Books.

This book classically identifies and describes mental health consultation and its four types: client-centered case, consultee-centered case, program-centered administrative, and consultee-centered administrative.

Gallessich, J. (1982). *The profession and practice of consultation.* San Francisco: Jossey-Bass.

This handbook organizes theoretical and practical information of considerable interest for consultants, trainers of consultants, and consumers of consultation services.

Goodstein, L. (1978). *Consulting with human service systems.* Reading, MA: Addison-Wesley.

This readable paperback contains much practical material on how to consult with the public sector. Its attention to organizational consulting is especially useful.

Kirby, J. (1985). *Consultation: Practice and practitioner.* Muncie, IN: Accelerated Development.

This book emphasizes a very practical approach to presenting consultation, including many examples. The facilitative-directive-terminating model is of special merit.

Lippitt, G., & Lippitt, R. (1978). *The consulting process in action.* La Jolla, CA: University Associates.

This small paperback provides an excellent summary of the consulting process.

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CHAPTER 8

USE OF MEDIA: AN INDIRECT METHOD

As you have read throughout this book, no longer is the professional counselor confined to the practice of individual counseling, although it is still the mainstay. Indeed, use of the media may best represent the innovative ways that counselors and counseling psychologists can help others. No more clearly can this be seen than in the use of media to achieve primary prevention goals.

What is meant by the "media?" Media are channels of communication. With such a definition, radio, television, and newspapers come to mind immediately. But in today's world, a multitude of other communication channels exist, also.

Permit me to describe a recent and intriguing innovation in use of the media for primary preventive purposes. In this approach, the classic Shakespearean play, "Romeo & Juliet," is the center-piece of a suicide prevention program sponsored jointly by the Folger Theatre in Washington, D.C., the Youth Suicide National Center, and the American Association for Counseling and Development.

You all know the extent of the adolescent suicide problem in this country. It is the second leading cause of death among the 11 to 24 age group, with as many as 400,000 attempts and 7,000 completions each year (Haffen & Frandsen, 1986). As Capuzzi (1986) has said, "Suicide prevention measures can and should be taken at the elementary level and continue through middle and high school years...early intervention and prevention would seem essential" (p. 7).

The school counselor's role, and that of other professionals in the schools, can be critical in this effort. Recognizing that, the Folger Theatre recently held a conference for school counselors, teachers, and school administrators on how to use "Romeo & Juliet" to examine teenage suicide (Mason, 1986). It was pointed out that the emotions and family relationships experienced by these characters are the same as those encountered by young people today. For example, Juliet does not have any friends. Romeo is sad and depressed, and he confides his suicide plans to friends after swearing them to secrecy.

Counselors were encouraged to use the play's themes to confront the fears of teen-agers, to educate them about the tragic consequences of suicide, and to teach positive alternatives for dealing with bad feelings. In that regard, a comprehensive package of materials demonstrating how to use the play to discuss suicide with adolescent students is available.

Of course, plays are but one of many communication channels that are available for use by the clever primary preventive counselor. While other breakdowns are possible for purposes of this chapter, media have been classified under three headings: (1) print, (2) electronic, and (3) simulation gaming. These are presented in Chart 8.1 with illustrations of media identified for each.

The media afford an impressive array of indirect services that can be used by professional counselors and counseling psychologists for primary prevention and other purposes. Allow me to provide some illustrations that are drawn from the print, electronic, and simulation gaming forms of media.

ILLUSTRATIONS OF AVAILABLE MEDIA

Print Media

The range of print media is astounding, as can be observed in Chart 8.1. Just three forms will be briefly discussed: posters and charts, newsletters, and pamphlets and booklets.

MEDIA CLASSIFICATION	ILLUSTRATIONS	
Print	Pamphlets	Programmed instructional manuals
	Newspapers	Booklets
	Journals	Magazines
	Newsletters	Books
	Photographs and other art forms	Articles
	Questionnaires	Survey results
	Posters and charts	Tests and human relations instrumentation
	Handouts	Chalkboards
	Bumper stickers	Buttons
		Tip sheets
Electronic	Television	Telecommunications
	Radio	Videodisc players
	Telephone	Audiotape
	Videotapes	Audiocassettes
	Videocassettes	Overheads
	Movies	Biofeedback
	Slides	Public service announcements
	Computers and their software	
Simulation Gaming	Games	Structured exercises
	Models	Learning activities packages

Chart 8.1. Three major classifications of media with illustrations for each.

Posters and Charts. Information presented on posters and charts can raise awareness of health issues. Erroneous beliefs, attitudes, and behaviors can be challenged. Readers can be enticed to look into a subject more fully by being directed to other sources for assistance (Ewles & Simnett, 1985). While posters and charts can be made inexpensively at home or in the office, high-quality materials and graphics prove to be both more eye-catching and retained.

A calendar which contains 12 mental health posters (Mental Health Association of Oregon, 1978) nicely illustrates how mental health promotion can be made available and accessible to large numbers of people. Its creators state that the ideas on the colorful calendars are meant for sparking ideas, for brightening spaces, and for improving mental health. I discovered the November poster of this calendar taped to the refrigerator door of a family I visited recently.

Mental health promotion suggestions are presented in these posters for each day of the year. Here are some of these suggestions for certain days in the month of November: "Challenge yourself;" "Take yourself to lunch;" "Ask an older person what he or she thinks;" "Keep quiet;" "Forget an old grudge;" "Watch the leaves blow;" "Hike a mile;" and "Take the risk."

The Alcohol Education Center I directed has used a similar approach in reaching in-coming students at the University of Cincinnati. As one example, we printed book marks that were made available to these students at registration and in the university bookstores for free. This bookmark contained the media message, "You don't have to get drunk to have fun," the logo that we use on all of our publications, a listing of some alcohol abuse facts, some attractive alternatives to drinking suggestions, and a list of pertinent university resources.

Newsletters. This mode of communication seems to be increasing radically these days. Newsletters are directed either at professionals or at the public. Examples of the former case include newsletters for private practitioners, for those interested in campus ecology, as well as the newsletters of professional associations (such as the *Monitor* of APA and the *Guidepost* of AACD). We even began one in my Office of Student Life (1986) called, *Correspondence,* through which we seek to inform faculty and staff of important issues affecting students at the University. Illustrations of newsletters for the public address a wide breadth of topics, as well, including those of nutrition and wellness.

The University of California, Berkeley *Wellness Letter* (1986) provides a case in point. During its two years of existence, this newsletter has published over 400 brief articles and focused reports on a broad expanse of wellness topics, including exercise, nutrition, medicine, stress management, sports, and environmental issues. I subscribe to this publication and find it to be chocked full of useful information for people interested in wellness and primary prevention issues.

Pamphlets and Booklets. Short, attractive, easily-read materials are widely available on a broad spectrum of educational and health topics. These include topics such as self esteem, personal development, coping skills, drugs and alcohol, study skills, decision making, getting along with others, career education, job skills, career choices, family relations, human sexuality, interpersonal relationships, discipline, and preparation for college—to name a few (Social Studies School Service, 1986).

For instance, the Student Organizations and Activities Department of the University of Cincinnati uses the *Scriptographic* booklets, published by Channing L. Bete, both in the context of workshops and as "stand-alone" resources made available for interested students to pick up when they come by the office. These colorful and informative booklets concisely address topics of concern to students, such as, "What Everyone Should Know About Wellness" (Bete, 1982), "How To Have Successful Meetings" (Bete, 1983), "How To Develop Your Leadership Skills" (Bete, 1984), and "What Everyone Should Know About Depression" (Bete, 1980).

Along with the newsletters, described above, pamphlets and booklets allow for readers to be self-pacing and self-teaching. When information is concisely and attractively presented, this approach can be very effective in providing primary preventive messages. When used as a stand-alone approach, however, as is often the case, the actual mastery and use by readers of these messages is uncontrolled by the professional.

Electronic Media

As technology has exploded, the variety of electronic media available for use by professional counselors has greatly expanded. The ones addressed in this section are audiotapes and audiocassettes, videotapes and videocassettes, and computers.

Audiotapes and Audiocassettes. These resources are especially suited for self-help and small group work (Ewles & Simnett, 1985). They can be constructed to convey information, pose problems, and trigger discussion. Because they can be stopped and started with ease, audiotapes and audiocassettes can facilitate re-examination and discussion. They prove useful for skill development in such areas as relaxation and exercise routines. These resources can be purchased, with instructions already contained. (Note well: Buyer, beware! Some of these may be more "slick" than "sound"). Or, they can be created as the equipment needed is now widely available. Drawbacks to the use of these materials are that making a good quality recording requires studio facilities, they fail to hold attention as well as their visual counterparts, and—as anyone who has listened to an audio recording of a group counseling session can appreciate—acoustical problems often can occur.

The *Encountertapes* (Berzon, Solomon, & Reisel, 1972) illustrate the use of pre-designed audiotapes for personal development through leaderless small group participation. Each of 10 small group "encounter" sessions is conducted with members following the paced and sequenced instructions contained on each audiotape. In brief, the topics for each two-hour session are Session 1, Introduction; Session 2, Ground rules; Session 3, Feedback; Session 4, Progress report; Session 5, Secret pooling to encourage self disclosure; Session 6, Break-out, to deal with inclusion and exclusion; Session 7, Descriptions; Session 8, Strength bombardment; Session 9, Giving and receiving; and Session 10, Conclusion, where learnings are summarized and good-byes are expressed.

The structured activities in which members participate are meant to progressively move them through the stages of group life and, by so doing, to develop enhanced personal and interpersonal development. Evaluation results have been moderately encouraging. The extensive study by Lieberman, Yalom, and Miles (1973) found these groups to be about as effective as the leader-led groups that they studied. Yalom (1975) commented that the self-directed tape groups of that study were, "safe, supportive, low-key groups" (p. 431). When I (Conyne, 1974) compared them to groups where designated leaders following the same instructions also were used, the self-directed tape groups fared well, but not as well as the others.

In general, as a mental health and primary prevention resource, the audiotape approach has shown itself to be useful, if employed carefully.

Videotapes and Videocassettes. These modes can do all of what the audio versions can, and more. For instance, reality can be more fully conveyed (Ewles & Simnett, 1985). Movement, sound, places, and emotion become presentable to an audience. Thus, for example, the nonverbal behavior of group members can be observed, as can the full scope of childbirth. Because video equipment is becoming ever more affordable and usable, productions can be created to portray issues of one's choosing. A unique advantage of video is that specific skills can be demonstrated to learners, the learner's mastery of these skills can be videotaped and observed, and the sequence can be repeated. This process reinforces and facilitates skill development.

Videos, often with guide books, are available for a number of personal and interpersonal topics. For instance, Kagan's (1980) interpersonal process recall method uses videotape playback to teach and refine complex interpersonal skills, including the responses of exploration, listening, feeling, and honest labeling. He asserts that these skills can be learned in only a few hours of practice and that this process can be useful with individuals, families, and groups, as well as with counselors and physicians.

Another example of a video tape, called *The Next STEP Video* (Dinkmeyer & McKay, 1987), focuses on showing parents how they can take care of themselves better and how they can change their behavior to benefit both themselves and their families. Its creators say the video will allow parents to be reached with maximum impact, and that it is especially useful in working with parents who may have difficulty reading. *The Next STEP Leader's Guide* includes directions for using the video with the overall program.

Videotapes can be produced locally, also. Colleagues and I (Conyne, Clack, Rapin, & Bowen, 1975) developed a series of videotapes on "Black-White Relations" that was produced by the university media services. Common student incidents were enacted, using a trigger format, to promote observer discussion following viewing. One example was of a loud stereo being played by Black roommates in their residence hall and the difficulty their White neighbors felt in confronting this situation. In another incident we taped, Black students were shown grappling with the frustration of becoming involved in a classroom comprised mostly of White students and a White instructor. These videotapes became part of an undergraduate interracial relations course we taught at the university, as well as a frequent training device we used with residence hall advisors.

Computers. Computers are now a fact of life in the helping world, and they will contribute strongly to its fast-paced evolution in the future. The two following examples illustrate these facts. Reardon, Shahnasarian, Maddox, and Sampson, Jr. (1984) presented a counseling colleague as saying:

> Three years ago, I would never have imagined that I would spend the first half hour of my day turning on and checking computers that students will use. Even more farfetched was the thought that I would feel lost if the computers were down and unavailable. (p. 180).

Backer (1985) envisions the future of organizational consulting through a scenario, a portion of which follows:

> Elizabeth Allan scans *The Wall Street Journal* as she drinks her morning coffee. Finished with breakfast, she walks from the dining room into her office and begins another busy day in her organizational consulting practice...Dr. Allan turns on her computer, and composes a report for a client...The office walls are lined with videocassettes, books, and several racks of computer software...Dr. Allan's day will end with a visit to a difficult client, an entrepreneur who's fought getting the latest technology into his office...This is Round 3 of the encounter, and while she doesn't win, Elizabeth Allan will return to her home-office at 7:15 PM feeling she made some progress. It is March 3, 1991. (p. 17)

Computers are being used to assist helpees in numerous ways. According to Sampson (1982), both direct and indirect applications of this technology are available. In the direct uses, the helpee interacts immediately with the computer terminal in order to advance his/her learning. Examples of direct involvement include the System of Interactive Guidance and Information (SIGI), which is a computer-assisted guidance tool for teaching decision-making and for facilitating the career decision-making process (Katz, 1980). In another piece of software called, "Alcohol: An Educational Simulation" (Marshware, 1984), an Apple diskette takes the user through the effects and dangers of alcohol consumption. As a part of this program, users play a computer game simulating the likely results of alcohol on their reflexes and judgment, and an animated car illustrates a crucial ride home from a party after drinking.

As well, computers have many indirect applications. These are considered indirect because computer services are employed without the helpee's direct participation. They also could be called "supportive" applications. Included in these uses are the processing of evaluation and research data, the word-processing of reports, and creating and main-

taining records and filing systems. Were it not for the computer, software, and printer that I am using to compose (I suppose one cannot refer to the process as "writing" in this case) this book, I would be in deep trouble! For some time a disbeliever, I can now attest to the power of this technology in providing indirect services. In fact, my wife recently asked if I would be able to write by hand again, after having realized the fruits of computer composing.

Simulation Gaming

Simulation games simplify complex issues problems in an atmosphere of involvement and fun. All over the country, educational and health agencies are using them as learning experiences to gain a clearer understanding of the social-psychological aspects of health behavior. And larger numbers of professionals are involving helpees in simulation gaming as a way to reach decisions. As Sleet and Corbin (1979) pointed out, the application of simulation gaming to health practices is "a new, exciting, and refreshing innovation" (p. 177).

Simulation gaming seems to be effective, at least according to a national survey of classroom teachers (Harwell, 1977). These teachers reported games and simulations to be among the top three teaching aids they use, largely because of the involved engagement they generate. One simulation game is described in the next section to give an idea of how they work.

The Ungame (Zakich, 1984). This board "game" provides noncompetitive opportunities for two to six players to share their thoughts and feelings. Players move tokens on the board and, depending on where they land, they must draw a card and respond to it, ask a question of another player, make a statement, or follow other directions. All action centers on what the players think, feel, and do about situations with which they are confronted in the game. Two decks of cards are included, each of which poses situations asking for a response. Situations contained in the first deck are lighter, used for warm-up and the establishment of sharing norms in the group. Examples include, "What do you do when irritated?" Situations contained in the second deck of cards are more serious, to be used after the players have practiced sharing, listening, and interacting. Examples of these situations include, "What do you most dislike about yourself?" and "What do you think about when you can't fall asleep?"

Several versions of the game exist. These include: All Ages (sample question: "Which of your senses do you value most?"); Singles (e.g., "What two qualities are important to you in a relationship?"); Family (e.g.., "What is something you really need from your family?"); Couples (e.g., "Describe your marriage in one word."); Teens (e.g., "What would you do if your best friend started using dangerous drugs?"); and Kids, ages 5-12, (e.g., "Mark and Matt are good friends. How would *you* describe a good friend?").

This simulation game, and others that have been developed, such as *Drug Debate* and *The Total Person,* are used as an adjunct to on-going counseling or they can be used as a primary preventive tool by those who are currently doing well. Although evaluation data are unavailable, game designers believe that these simulations can lead to personal growth—that is, a better sense of how one appears to others, discovery of personal skills and abilities, clarification of fears that weren't there before, and opportunities to express anger, affection, and indifference in an atmosphere of trust and support (Sleet & Corbin, 1979). Indeed, when used with presently healthy people, this is the stuff of primary prevention.

GUIDELINES FOR USING MEDIA

Despite the fact that an attractive array of media forms exists for use in primary preventive counseling, they offer no panacea or magic. Indeed, Wilson, Conyne, Bardgett, and Smith-Hartle (1987) attest to this reality with regard to the marketing of personal enhancement groups on a university campus. Here, the reliance on a mass media approach of campus newspaper notices and the wide posting of flyers across campus failed to deliver interested group members. In the article was shown how specific social marketing strategies were applied to correct this difficulty (e.g., Kotler & Zaltman, 1971).

Even though media can potentially reach large numbers of people economically, media will be effective only when used properly and carefully (Lazes, 1979; McAlister & Berger, 1979). Some general guidelines for using media may be useful to consider (Grover & Miller, 1976):

1. *Define outcome measures.* What learner behavior do you intend to change? Answers should shape the media chosen, and the style and content to be used.

2. *Analyze pertinent characteristics of the learner.* Assess motives, beliefs, and the milieu of the learner in terms of supports and impediments to change.

3. *Secure and maintain the learner's attention.* Identify the learner's main interests. Use change, action, novelty, and color in media techniques. "KISS" (Keep It Simple, Stupid!). Find ways to directly relate the message to the learner's experience.

4. *Demonstrate a need for action.* Negative consequences of the failure to act should be made explicit.

5. *Establish the learner as an agent.* Indicate specific actions the learner can take immediately to reduce or prevent the possible negative outcomes.

6. *Establish the concept of self-efficacy.* The learner must become convinced that personal action will work.

7. *Provide practice.* Performance-based feedback should be given, whenever feasible. This feedback should be specific, and it should address attainable, observable, and measurable outcomes.

8. *Repeat key facts.* Repetition of critical information should occur attractively throughout the media effort.

9. *Generalize to similar situations.* Critically for primary prevention, the learners should be helped to apply the information presented to present and future other situations in their lives.

SYSTEM CHANGE

As is our custom, let us now explore how media can be used to reach primary prevention goals for our system change and for person change. Chart 8.2 highlights the material that will be covered.

CHANGE APPROACH	INTERVENTION	ILLUSTRATIVE KINDS OF MEDIA
System	Mass Media	Television Radio Magazines Newspapers Books Displays Exhibitions
Person (Competency Enhancement)	Media plus Intentional Personal Support	Personal contact Modeling Reinforcement Interactive feedback Group interaction Encounter group

Chart 8.2. Media intervention for system and person change, with illustrative kinds of media.

Mass Media

Media interventions for system change can be grouped under the label of "mass media." The mass media are the channels of communication that are used to reach large groups of people, if not an entire population, often through television, radio, magazines, newspapers, books, displays, and exhibitions (Howitt, 1982). For instance, mass media are being used to bring to public attention the threat to the public health presented by the AIDS virus, the dangers of cigarette smoking and drinking alcohol, the life-extending benefits of a low cholesterol diet and proper exercise, and methods to reduce personal stress.

Mass media are the primary tool of social marketing (Manoff, 1985) which, in turn, involves the design, implementation, and control of programs to increase the acceptability of a social idea or cause in a target (Kotler, 1982). When used properly, the mass media have been found to be generally effective in raising health consciousness, increasing health knowledge, and arousing an immediate emotional response (Ewles & Simnett, 1985). They have been found to be of some success, also, in producing simple behavior change (McAlister & Berger, 1979), such as substituting margarine for butter. All of these attributes of effective mass media use can contribute to influencing a climate of public opinion that will support a significant social change, such as seat belt legislation and the no smoking ordinances being enacted in many cities in this country. These kinds of changes hold much potential benefit for system change.

However, the overall and consistent effectiveness of mass media projects to produce significant system change or substantial alteration in the complex behaviors of a large group of people is questionable. Many observers, such as McAlister and Berger (1979), argue that external, environmental support is necessary for complementing mass media efforts in order for them to change difficult behaviors, such as smoking cessation. In this line of thinking, the mass media alone represent an insufficient approach. Although this kind of environmental support sometimes gets generated and becomes instrumental to the success of mass media efforts, it is generally incidental to the project, rather than central to its execution.

Others, however, such as Manoff (1985) and Maccoby and Alexander (1979) have pointed to the ineffectiveness of mass media approaches resulting as much from the failures in mass media program design and delivery as they do to the importance of environmental support. In all likelihood, both positions are valid.

Despite inconsistent results and conflicting explanations for them, a number of mass media efforts have met with considerable success. These projects have usually been "multimedia" in design (i.e., they included multiple forms of media), and they have been successful at stimulating environmental support.

These mass media projects include, but are not limited to, the Finnish North Karelia Project (Koskela, Puska, & Tuomilehto, 1976), which used television and group pressure for smoking cessation; the Contracep-

tion Project in Bengladesh (Schellstede & Ciszewski, 1984), which used a minidrama on radio and television to promote contraceptive use; the Stanford Three-Community Study (Maccoby & Alexander, 1979), which produced significantly positive cardiovascular change at the community level through mass media education; and the "Friends Can Be Good Medicine" project (Taylor, Lam, Roppel, & Barter, 1984), which used combinations of mass media and community involvement throughout the state of California to produce lasting gains in knowledge, attitudes, and behavioral intentions regarding the importance of friendship and social support in personal mental health.

To conclude this all-too-brief section on the use of mass media for system-level change, the words of the designers of the "Friends Can Be Good Medicine" project seem apropos (Taylor et al., 1984):

> The way we live our lives strongly influences our health and well-being. For that reason, mass media—with its awesome reach and ability to change perception and behavior—must be viewed as a powerful component of the health care system, for better or worse...The challenge for the health-related public sector is to develop effective ways of harnessing mass media in the interest of health promotion... (p. 302)

PERSON CHANGE: COMPETENCY ENHANCEMENT

Carefully constructed and delivered mass media programs have been shown capable of producing information gains and simple behavioral change, both of which can be lasting. For instance, Munoz, Glish, Soo-Hoo, and Robertson (1982) used television educational programming to prevent depression from developing in a sample of normal adults, aged 18 years and above. The ten TV segments, which were based on social learning and self-control techniques (Lewisohn, Munoz, Youngren, & Zeiss, 1978), were each 4 minutes long. They aired during noon, evening, and nightly news throughout the week for a period of two weeks. In general, results showed that viewers, compared with non-viewers, took more time to relax, told themselves to stop thinking negative thoughts more often, and they identified more ways to keep from becoming depressed. These findings suggest that individuals can gain preventive skills from carefully presented mass media projects.

But for achieving enduring complex change in personal competencies, it appears that some element of intentional personal support is

needed to complement the mass media effort. The importance of intentional personal support can be seen best in the skill development approach to competency enhancement.

Intentional Personal Support in Skill Development

Person change can be part of a mass media effort, such as any of those mentioned previously. Or, it can be sought in more circumscribed ways, drawing selectively from any of the print, electronic, or simulation gaming areas presented earlier in this chapter. In either case, an emphasis is placed on facets of the media project having to do with *intentional personal support,* such as personal contact, modeling, and reinforcement.

Bloom (1971), for example, conducted a primary prevention program to reduce dropouts among freshmen in one university. His innovative media project attempted to build intentional personal support through providing interactive feedback to students who regularly completed questionnaires documenting their experience as freshmen. By doing so, Bloom sought to develop a "psychological sense of reality" among the participants.

Frequently, however, this intentional personal support is provided through group interaction of some kind. Two examples of such projects follow, both of which used community small group discussions to intentionally enhance health promotion messages broadcast over television.

Northern Berkshire Health Promotion Project (McAlister & Berger, 1979). This was a large-scale smoking cessation project undertaken in five Massachusetts towns. It combined the mass media approach of cable television with planned self-help group discussions. These small groups consisted of from five to ten members. They were conducted throughout the five communities for ten one to one-and-one-half hour sessions over a four-month period.

Cable TV allowed for the rapid, controlled, inexpensive, and extensive transmission of expert information, advice, and practice exercise instructions to participating community members. The self-help groups, each of which had its own volunteer group leader (usually an ex-smoker), provided for the personal support and reinforcement of peers, as well as for social incentives and group facilitation from the leaders.

Because the purpose of this project was to help smokers to stop, its emphasis was secondary prevention, at best. However, the marriage of a community mass media approach, such as cable TV, with the intentional personal support provided by small group interactions, provides a valuable model for primary prevention efforts.

Self-Directed Groups and Community Mental Health (Farson, 1972). This project was reported in an edited book (Solomon & Berzon, 1972) containing innovative ways to apply a human relations phenomenon of the 1960s and 70s, encounter groups. I have found this model, which is similar to that used in the Northern Berkshire project, to be highly appealing and have adapted it to different primary prevention projects I've been involved with over the years (e.g., Conyne, Clack, Rapin, & Bowen, 1975, on improving Black-White student relations). The basic technology is being used extensively to address many other contemporary educational, social, and psychological problems, such as illiteracy, teen-age suicide, and drug abuse in the schools.

Farson's project was conducted as much to test the efficacy of self-directed groups in community mental health as it was to explore the potential of television as a medium to promote mental health in participants. Moreover, these means were employed to strengthen community members by decreasing their 20th century sense of alienation and anomie and showing them how they can be helpful resources to each other.

In this still innovative 15-year old primary prevention intervention, volunteers were carefully selected to interact in a 13-week basic encounter group that was unrehearsed and videotaped. Important incidents from each session, plus a brief commentary from the group leader, were shown in subsequent weekly one-half-hour television programs. The 120 viewer-participants were arranged into small, self-directed groups throughout the San Diego community. These individuals viewed the weekly incidents and commentary and then engaged in their own encounter group, using the viewed material as a stimulus for their involvement. As contrasted with the Northern Berkshire methodology, these groups were truly self-directed, having even no pre-designated lay leader present.

All of this activity was fairly closely monitored through diaries, follow-up sessions, and other forms of data collection. Results were encouraging for this sort of mass media and self-directed group project.

With reference to the technology used, which is our current concern, Farson (1972) observed that

> The plan was feasible. The use of the television program as a stimulus for the community groups, this instance only twelve, could just as easily have involved 1,200 or 12,000 groups...I see televised group activity as having two points of impact: The first is the use of the medium as stimulus material for groups that could meet in the community. The other is the ability of this type of programming to simply show what it's like to be a human being. (pp. 230, 232)

While I would be uncomfortable about providing a completely self-directed experience in a community, such as was done in Farson's program, the model can be adapted (at some cost) to include trained and supervised community group leaders, as was done in the Northern Berkshire effort. Regardless, the two projects summarized in this section clearly illustrate the tremendous potential that exists for integrating mass media with intentional personal support to yield innovative primary prevention projects.

The "wide, wide world of media" is nearly completely untouched by professional counselors and counseling psychologists. It is a world full of wonder and promise for primary preventive counseling. We need but to become informed and more willing explorers.

SUMMARY

Print, electronic, and simulation game media were considered in this chapter. These media were shown to be an important and underused indirect intervention for primary preventive counseling.

Guidelines for using media were outlined, followed by a discussion of applying the media for both system change and person change. The mass media took center stage at this point, and a variety of successful mass media projects were either referred to or briefly described. An emphasis was placed on the important role of intentional personal support as a complement to any media project that attempts to produce person change (as most do). Particular attention was given to two projects that explicitly included this dimension in their design and execution, the Northern Berkshire project on smoking cessation, and the Self-Directed Community Group project on personal development.

Finally, professional counselors and counseling psychologists interested in primary prevention were encouraged to become informed and

involved with using the media. The "wide, wide world of media" use awaits investigation and experimentation.

This chapter concludes Section II on direct and indirect interventions in primary preventive counseling. In Section III is addressed a significant issue facing primary preventive counseling: the importance of program planning and evaluation.

ISSUES FOR REFLECTION AND DISCUSSION

1. Three categories of media that are suitable for use in primary preventive counseling were discussed, with examples. Name them and give three illustrations of each category.

2. Select one media category and show concretely how a primary preventive counselor might use it.

3. Nine guidelines were presented for using media appropriately. List them. Select a media intervention (e.g., using the computer for primary prevention of alcohol abuse), and apply these nine guidelines.

4. Mass media are associated with system change and with large group intervention. Define "mass media." Identify their strengths and weaknesses.

5. Some mass media projects have realized considerable success. Identify two of them and their general areas of concern.

6. What is meant by the term, "intentional personal support?" What is its place in media interventions for person change?

7. Describe how small group involvement was used in the Northern Berkshire Health Promotion and in the Self-Directed Community Group projects. What were its main benefits?

8. What is your thinking about the use of media for primary prevention purposes? Explain.

HIGHLY RECOMMENDED SUPPLEMENTARY READINGS

Bloom, B. (1971). A university freshman preventive intervention program: Report of a pilot project. *Journal of Consulting and Clinical Psychology, 37,* 235-242.

> This article presents a novel and well-designed primary prevention media intervention on a college campus that holds both theoretical and practical importance for counseling psychologists.

Ewles, L., & Simnett, I. (1985). *Promoting health: A practical guide to health education.* Chichester, England: Wiley.

> This clearly written book lives up to its subtitle of a "practical guide." We can learn much about health promotion and primary prevention from our health educator colleagues.

Farson, R. (1972). Self-directed groups and community mental health. In L. Solomon & B. Berzon (Eds.), *New perspectives on encounter groups,* 224-232. San Francisco: Jossey-Bass.

> This short chapter has always been a classic for me. It clearly shows how television and self-directed groups can be combined in a community to present primary prevention programs.

Lazes, P. (Ed.). (1979). *The handbook of health education.* Germantown, MD: Aspen Systems Corp.

> This edited book, again drawn from the field of health education, covers many relevant areas for health promotion. Its attention to media usage is very helpful, including the chapters by McAlister and Berger, and by Sleet and Corbin.

Maccoby, N., & Alexander, J. (1979). Reducing heart disease risk using the mass media: Comparing the effects on three communities. In R. Munoz, L. Snowden, J. Kelly, & Associates (Eds.), *Social and psychological research in community settings,* 69-100. San Francisco: Jossey-Bass.

> This ground-breaking intervention is fundamental to an understanding of how media can be used to reduce serious health risk. The model employed is applicable to primary prevention of educational and psychological troubles.

Manoff, R. (1985). *Social marketing: New imperative for public health.* New York: Praeger.

> Social marketing and public health are important contributors to primary prevention. This book does a good job at indicating their relationship, and how mass media can be involved.

Taylor, R., Lam, D., Roppel, C., & Barter, J. (1984). Friends can be good medicine: An excursion into mental health promotion. *Community Mental Health Journal, 20,* 294-303.

This exciting multi-media campaign in California emphasized the role of friends and social support, resulting in primary preventive gains.

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SECTION III

QUALITY ASSURANCE

INTRODUCTION TO SECTION III

Many programs and services being offered today are said to be "primary preventive." As we have seen in this book, fully satisfying the criteria for determining whether primary prevention goals are actually being met by any one program is difficult. It is highly likely, therefore, that a large number of offerings currently wrapped in the banner of primary prevention may not truly qualify. For instance, a target group may not be at risk, an intervention may not be offered before-the-fact, or nothing may have been prevented by the effort.

These critical comments are offered not to discourage or nay-say explorations in the area of primary preventive counseling. Rather, let them serve to introduce the importance of assuring quality throughout every phase of effort that is undertaken. This kind of quality can be best assured through being certain that sound program planning and evaluation processes are in place for any primary preventive counseling activity.

Proper program *planning*, for instance, allows one to develop a credible conceptual base, to accurately identify community needs, to determine at risk groups, to establish attainable preventive goals, and to design an intervention program that is both conceptually and practically valid. Program *evaluation* allows one to determine if the intervention is being delivered according to plan, if modifications are required along the way, and if the program goals were met. Program planning and evaluation are fundamental processes to aid in being sure that the program is designed with reference to primary prevention criteria and is being implemented accordingly. If these are done, then the program will have its best opportunity to demonstrate desired primary preventive effects.

The APA Task Force on Promotion, Prevention, and Intervention Alternatives in Psychology recently announced 14 "showcase" primary prevention programs that were selected from 900 nominees (Bales, 1987). (Several of these programs have been mentioned in this book.) One of the critical criteria these programs had to meet successfully was to show program evaluation effectiveness. "We wanted to identify programs that worked and had documented evidence of their effectiveness," said Richard Price, the task force chair (Bales, 1987, p. 18). This intention cuts directly to the heart of the program planning and evaluation process.

Thus, program planning and evaluation are essential to the assurance of quality in primary preventive counseling. The material contained in Chapter 9 will be helpful for anticipating planning and evaluation issues and for effectively working with them.

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CHAPTER 9

PROGRAM PLANNING AND EVALUATION

IF YOU DON'T KNOW WHERE YOU'RE GOING, HOW WILL YOU KNOW IF YOU GOT THERE?

Planning—whether for a long trip, a financial future, or a primary prevention program—helps to ensure the directed use of resources to reach stated goals. While planning cannot guarantee, it does increase the odds for success.

Planning increases in value in direct proportion to the complexity of an intended activity. A personal note here may be illustrative. I love to "hang-loose," to do things spontaneously, whenever possible. These times have passed for a few years, I suspect. Now, with the birth of two children who are aged three years and nine months, my wife (who is a practicing psychologist) and I must plan, plan, and plan some more in order to accomplish even the most mundane of activities, such as shopping. Our situation has increased in complexity, requiring us to now be very organized and planful in trying to lead as balanced a life as possible.

Conducting primary prevention programs is an involved and complex endeavor (Heller, Price, & Sher, 1980). A key ingredient to success in this effort is to include a thorough planning process. As Craig (1978)

wrote on the fly-page of her excellent planning and evaluation manual, "The more you know about where you're going, the closer you are to being there..."

GETTING THERE IS ONE THING, BUT IS IT THE RIGHT PLACE TO BE?

This question is illustrated by the story of the prisoners who developed an elaborate escape plan that involved digging a one-half mile tunnel under the prison with spoons and other pointed objects they had managed to pilfer. After three years of dangerous and exhausting work, they broke through the ground at their planned target site, only to find themselves still well inside the prison yard! Demoralized and dejected, their jig was up.

What had happened? The plan itself was accurate and detailed. Had it been faithfully followed, the prisoners would have exited outside the prison grounds, their escape attempt a success. Yet, the execution of the plan went awry. So many years, so many people doing the digging, so dark down in the tunnel, men becoming so tired. Mistakes were made. A few wrong turns unknowingly taken here and there. All of this led to the plan's failure and the resulting disastrous outcome.

The prisoners had a good plan, but they wound up in the wrong place. Evaluation is necessary to help assure that energies are being directed in accordance with the plan that has been developed and to determine if goals of the plan have been satisfactorily met.

IMPORTANCE OF PLANNING AND EVALUATION

Writers in the field of primary prevention are clear that planning and evaluation are critical functions. Morrill, Oetting, and Hurst (1974), in discussing their dimensions of counselor functioning "cube" (see Chapter 4 of this book for coverage), emphasized that assessment and evaluation comprise one set of counselor functions that overrides all others. Wilson and Yager (1981) strengthen this perspective with regard to prevention programs by offering that

> Our belief is that imaginative and competent planning of prevention programs requires a research orientation to the conceptualization, development, implementation, and evaluation of the task. Realistic and effective prevention programs are based on good research entailing a logical, systematic, developmental approach. (p. 590)

Cowen (1984) added additional support to this theme. He believed that, although primary prevention is recognized as an attractive alternative to the insufficiencies contained in the present (remedial) mental health system, its conduct can be improved significantly through use of a sound program development model that contains concrete steps, including evaluation.

These observations cogently suggest that, if primary prevention programs are to be effectively and efficiently delivered, planning and evaluation are essential applied research functions. In turn, as Price (1983) has indicated with regard to the field of preventive psychology, what will cause it to develop from a "worthwhile aspiration" to an "accomplished fact" is the creation of new prevention-relevant knowledge. He pointed to various forms of prevention research as being essential in this evolution.

PLANNING AND EVALUATION IN PROGRAM DEVELOPMENT

If one thinks linearly about program development, planning and evaluation occupy the first and last points in that process. Planning identifies what to do and how to do it. Evaluation shows how effectively and efficiently the program achieved the desired goals which, in part, is a measurement of how the program was administered. Sandwiched in between planning and evaluation, of course, is the actual program implementation itself. These three steps of Planning-Implementing-Evaluating (yielding the acronym, "PIE"), account for most of the program development model, but not all of it.

Program development is not a linear process. Rather, it is recursive and cyclical. What makes it so are the evaluation data that are produced, not only at the conclusion of the program (summative data about program outcomes) but, importantly, all along the way. This latter kind of information, produced through formative evaluation, tells implementers if the program is on target, if activities are occurring according to plan,

and other practical questions related to whether or not what was planned is actually being carried out. When the program development process is working properly, evaluation data are fed-back regularly during the project to keep it "on-course," and at the project's conclusion, to determine if outcome goals have been met. Thus, a total program development model includes four broad, generic elements: (1) *planning,* (2) *implementing,* (3) *evaluating,* and (4) *feedback* about both process and outcomes.

Most attention in program development, though, is paid by training programs and practitioners to program implementation. Everyone wants to know how to actually do something. This book has followed suit, by devoting considerable attention to the direct and indirect methods of primary preventive counseling.

While good reasons may exist for this, doing so unfortunately relegates planning and evaluating to a secondary position. The intent in this chapter is to locate planning and evaluating within the general program development model and to emphasize their important place in primary preventive counseling.

HOW PLANNING AND EVALUATION OCCUR

Three of the most incisive and difficult issues in determining if an intervention was primary preventive or not are (1) Was it offered "before-the-fact?" (2) Was the target group or situation "at risk" and currently unaffected? and (3) Did the intervention actually prevent the identified dysfunction; that is, was it successful? To resolve these issues, designers of primary prevention interventions must devote much more energy to the program development steps of planning and evaluation than is ordinarily given.

Any of the direct or indirect methods and interventions identified in earlier chapters of this book frequently are used for purposes other than primary preventive ones. Remediation is the most frequent reason. No primary preventive magic resides in the approaches themselves.

For instance, the indirect method of consultation is not exclusively a primary preventive one. Consultation becomes so only when it is conducted with references to *at-risk-groups prior to their disturbance.* The same situation applies to all the other methods and interventions con-

tained in the Primary Preventive Counseling model that has been described. Only through planning and evaluation is the necessary information acquired to produce interventions that are primary preventive in purpose.

Next, we will examine these essential program development steps of planning and evaluation as they relate to primary preventive counseling. Examples will be presented, as space permits, to highlight key points.

Planning

The step of planning is not only important, it is complex. Only limited coverage can be provided in this short chapter. You are encouraged to pursue other sources for in-depth coverage of this critical process (e.g., Coursey, 1977; Cowen, 1984; Craig, 1978; Moore & Delworth, 1976; NIAAA, 1978; and Wilson & Yager, 1981).

In general, planning includes five interrelated sub-steps. These are (1) identify a future program's "generative base," (2) assess needs and targets, (3) set goals, (4) select strategy, and (5) prepare for implementation. These sub-steps in planning are listed in Chart 9.1.

Identify the Generative Base. A generative base provides the conceptual underpinnings for identifying what should be attempted. It is derived from pertinent theory and research. According to Cowen (1984), a generative base is necessary in planning primary preventive programs because, "it provides prospective investigators with plausible leads about the types of interventions that hold promise for positive (primary preventive) payoff" (p. 485). Omitting this step can lead to doing entirely the wrong things, or doing what the intervener likes to do or does well, regardless of the situation.

The generative base is influenced by previously-gained knowledge. This knowledge may point to existing relationships between the presence of competencies and adjustment, or to the lack of competencies and maladjustment. For instance, considerable evidence exists to support the importance of interpersonal problem-solving skills in healthy functioning, and deficiencies in the same for unhealthy functioning.

SUB-STEPS	COMPONENTS
Identify the generative base	Obtaining plausible leads
	Review previously gained knowledge
Assess Needs and Targets	Use analytic strategies Participant observantion Ethnography Key informant interviews Network analysis Surveys Epidemiology Social indicators
Set Goals	Specify area, topic, or concern
	Delineate expected change in incidence (e.g., number, percentage)
	Identify specific target (e.g., age, sex, other demographic data)
	Describe time period (e.g., within 6 months, between Sept. 1 and May 1)
Select Strategy	Generate alternatives (possibilities)
	Analyze each alternative (feasibilities)
	Select one strategy (selection)
Prepare for Implementation	Who? When? Where? With what? How?

Chart 9.1. Sub-steps and related components of the planning process.

Or, existing knowledge could implicate the association of a situation, setting, or life circumstance with subsequent psychological dysfunction. Abundant evidence here implicates highly-competitive and non-supportive social environments, as well as such stressful life situations as divorce or unemployment, with a range of negative physical and psychological indices.

These and other kinds of knowledge bases have been developed. They can be drawn from to shape the direction of future primary preventive counseling projects.

Assess Needs and Targets. The generative base selected must correspond directly to actual issues in the community of interest. Assessing community needs and targets helps to determine what those actual local issues may be and which of them could profit from primary preventive counseling. This assessment of needs and targets involves analytic strategies (D'Aunno & Price, 1984), where the assessor assumes the role of a problem analyst (Price, 1983).

A number of analytic strategies are available for use in the assessment of needs and targets. These range from the highly qualitative, which emphasize observational, descriptive, and interview approaches, to the highly quantitative, which involve the collection and statistical analysis of numbers.

D'Aunno and Price (1984) have identified and described five broad analytic strategies for community research that span this qualitative to quantitative dimension. Beginning with the qualitative and moving to the quantitative end of the spectrum, these strategies are participant observation, ethnography, key informant interviews, network analysis, surveys, epidemiology, and social indicators.

While room does not permit defining these strategies, the important point here is that the problem analyst ought to be able to draw competently from a range of qualitative to quantitative assessment methodologies (Price, 1983). The combination of data which emerges from different sources and perspectives can inform the most validity about peoples' needs and situations.

For instance, in student retention research at the University of Cincinnati, survey research has been used to study the behaviors and experiences of freshmen students. Much was learned about these students'

work hours, involvement with faculty, intention to transfer, academic and social involvement, and other matters of importance, such as the finding that no direct correlation was found between grade point averages estimated by the respondents and their intention to re-enroll (Hadley, 1986).

In the second year of this study, the process will compare dominant behaviors and campus experiences of the drop-outs from the university (i.e., the "non-Sophomores") with those of students who did return for their second year. This information will provide leads as to what "retenters" do, versus what the "leavers" do not do, to remain at this one institution.

In addition to this quantitative approach, a complementary qualitative, ethnographic study is in progress, also. In this one, a doctoral student is closely studying the student lives of six freshmen as they go through their entire first year. The researcher is attempting to learn first-hand what these students say about their experience, the events that occur in the various university settings of which they are a part, and the meanings the students attach to these occurrences.

Information yielded from both of these assessments will assist in understanding more about what constitutes a "holding" campus environment, and about what student behaviors contribute to or detract from becoming positively involved and attached. Assessment results will guide subsequent program development steps aimed at reducing student attrition.

Set Goals. Goals indicate precisely how a primary prevention program will respond to needs or problems that were identified during the assessment step. They describe what the program is to accomplish.

Generally, primary preventive goals include statements of "incidence;" that is, they are geared to lowering the number of new cases of certain disturbance. Reducing the number of new teen-age pregnancies in a population, or averting depression among a group of newly divorced individuals, illustrate how the concept of incidence is important in primary prevention goals.

The goal statements themselves need to be as specific and concrete as possible. Concrete goals provide the guidance necessary to develop

methods of intervention and evaluation. They should be based on action verbs that describe observable behavior, they should identify the situation or circumstances where the behavior will occur, and they should indicate the criteria for determining success (Mager, 1962).

The two statements of incidence given earlier go only part of the way necessary. Vagueness exists. In the teen-age pregnancy instance, would reducing the number of new cases by one, or two, or by 3,000 all be considered a success? What teen-age population is being targeted? Is it teenagers of a neighborhood, a city, the whole state? Will resources be focused equally across the teen-age years, or will a more specific set of years (such as 15 to 17) be targeted? Will teen-age boys become a concern of this project, also, or will it be restricted to girls? A better goal statement would read, "to reduce the number of new teen-age pregnancies in Clinton County by 25%, by focusing on both boys and girls from ages 13 to 18."

A particularly useful method for developing primary prevention goals (and subsequent program steps) is found in the use of a representative task force (Moore & Delworth, 1976; NIAAA, 1978). While a task force is frequently assembled at the assessment step, I have found it more economical and just as effective to form it at the goal setting step, after assessment data have been collected, but before data analysis, discussion, and the determination of program goals have occurred.

Task forces are comprised of representative community members and professionals who hold some special stake in the issue at hand. For instance, with the teen-age pregnancy case, members might be drawn from families of teens, some teen-agers themselves, high school faculties, church staffs, and social service, political, legal, and medical agencies. Task force members join to form a core of representative knowledge and opinion. They guide the development, implementation, and evaluation of the primary prevention program, under the facilitation of the organizer, who, in this case, would be the primary preventive counselor. (Parenthetically, consider the competencies this individual would need to effectively manage this task force).

Working with these members provides some special advantages: (1) their information and views are cross-sectional, reality-based, and valuable; (2) they are aware of, or may control, sources of information and access to the target population; and (3) their cooperation and involvement can increase chances that the primary prevention program

that is generated will not only be on-course, but that it will actually be put into practice.

Moreover, implicitly within these advantages lies a golden nugget. Collaborating with a representative task force can go a long way toward answering a very common concern about doing primary prevention: "I want to do it, but how do I get started; how can I get involved on the primary preventive end, before problems are entrenched?"

Select Strategy. If program planners have not already jumped ahead to developing a "solution" to the identified needs, they are likely to do so now. This premature tendency toward quick closure must be resisted.

The appropriate step called for here—select strategies—includes three parts. These are: (1) to generate a range of alternative strategies for reaching the identified goals that have been established; (2) to analyze each; and (3) to select the one strategy that realistically holds the greatest chance for success. Price (1983) refers to this process as "innovation design."

A strategy is simply a series or group of activities that is conducted to reach designated goals. Alternative strategies can be generated in a number of ways. *Brainstorming,* the *Nominal Group Technique,* and the *Delphi method* represent three of the structured ways that this can occur.

For instance, brainstorming could be used to produce alternative strategies for reducing the pregnancy situation mentioned earlier. Members could be asked to quickly and without evaluation generate as many competency enhancement ideas (e.g., teach assertive skills) as possible, and then to do the same with system change ideas (e.g., introduce health clinics throughout the school district). Scores of such ideas can be produced by planning groups.

The next issue in strategy selection considers how feasible are these brainstormed ideas. Some may be too expensive, some may be obvious political bombshells, and some just couldn't be done for whatever reasons. A very useful exercise for determining the feasibility of the alternatives is *force-field analysis.* In it, the promoting and the restraining forces affecting each proposed idea are carefully analyzed. Other approaches consider feasibility strictly in terms of resources that would be required to carry out each idea. A third method for determining feasibility is to check these ideas against specific evaluation criteria, such as their

expected appropriateness, adequacy, effectiveness, efficiency, and side effects.

Finally, after the feasibility analysis is completed, program planners use the information to reach a decision about which strategy—or strategies—they will use to reach their primary preventive goals. They then proceed to the step of preparing for implementation.

Prepare for Implementation. Note well! Implementation has yet to happen! But the time and effort expended in these preliminary planning steps are absolutely critical to the effectiveness of whatever program will be implemented. Failure to plan thoroughly is virtually a guarantee to a failed primary prevention effort.

Once a strategy is selected to reach the desired primary prevention goal, the planners must turn to the very hard questions of who will do what, when, where, with what, and how? This is the "nitty-gritty" of planning. How many of you will admit to having been involved with creating a great plan that never was realized because concrete task assignments were left undone? Unfortunately, I have had such experience, although less often now. When it happens, I'm always reminded of the good-hearted folks who spent lots of time and money planning a special party to which no one ever came. How deeply disappointing!

In my experience, professional counselors and counseling psychologists tend to avoid the kind of detail work necessary for programmatic success. In primary preventive counseling, however, an essential aspect is to become practical in designing a strategy and the set of activities that comprise it. This means (1) to determine what major activities are needed within the strategy and in what order they must occur, (2) to create a specific and public time schedule for completion of these activities, (3) to identify what resources (e.g., personnel, supplies) are needed, and (4) to assign precise responsibility to persons for completing each activity (Craig, 1978).

Let us assume that the system change strategy of establishing school health clinics throughout an entire school district was selected by the planners to meet the teen-age pregnancy goal mentioned earlier. Think about the steps involved in "preparing for implementation," that you have just read about, and take a few moments to apply them to this strategy and goal.

Once this aspect of the plan is completed, implementation can occur. As you can plainly see, planning is complicated. Yet, it is fully capable of being mastered. Most importantly, as has been emphasized, effective planning is fundamental to success in primary preventive counseling.

Evaluation

Determination of success is an evaluative issue. Program evaluation is tied inexorably to program planning. It begins with the statement of goals and objectives, and proceeds through all subsequent planning steps. A truism is that the more precisely the primary prevention program is planned, the more easily and accurately will be the evaluation.

Basically, two major questions command the attention of the program evaluator: (1) Is the program being delivered according to plan? and (2) Is the program realizing the outcomes set out for it? These are issues of formative and summative evaluation, respectively.

These forms of program evaluation are organized in Chart 9.2.

DOMINANT FORMS	COMPONENTS
Formative Evaluation (Process)	Monitor (e.g., narrative reports, diaries)
	Feedback (regularly)
Summative Evaluation (Outcomes)	
Mid-Range Effects	Observation Self-report Interviewing Behavior checklists
Long-Range Effects	Experimental design Multivariate design Qualitative, n = 1 design

Chart 9.2. Dominant forms and components of program evaluation.

Formative Evaluation. Formative evaluation is used to determine how an intervention is proceeding. That is, the resources, activities, strategies, and goals of the intervention program are closely monitored to ascertain if they are being applied as designed, and if they need modification.

Narrative reports and diaries kept by the program planners and deliverers are often useful in determining if the intervention is occurring as planned, if any unexpected external events occurred (e.g., a large budget cut) that affected the program, and if alternatives are required. Feeding-back formative evaluation data in a timely way to decision-makers are essential if the information is to be effectively used to keep the program "on-track."

Summative Evaluation. Summative evaluation is used to determine if the planned outcomes were achieved. If so, it is used to identify whether the realization of outcomes can be attributed to the primary prevention program itself, or to some other cause.

Summative evaluation includes two levels. The first one can be considered *mid-range* in scope. It is concerned with if the intended behaviors or conditions that were to be produced by the intervention were attained. For instance, did participants in an assertiveness training workshop become more assertive by the program's end? Were the school health clinics established, and are they functioning? Measures of these mid-range outcomes include observation, self-report, interviews, and behavior checklists.

In the second level of summative evaluation, *long-range* outcomes are examined. This level is of particular importance to primary prevention programs, for it is through it that judgements can be made that reductions in incidence did, or failed, to occur. At this level it is possible to learn, for example, if the gains in assertion skills led the workshop participants to experience fewer interpersonal crises at work and in their families, and if the installation of health clinics in the schools led to reductions in teen-age pregnancy for the targeted students.

Although long-range effects in primary prevention programs are difficult to measure, to make the concerned attempt is very important. As Bloom has observed (Bales, 1987), many programs stop collecting data too early, resulting sometimes in the missing of program effects. Only through the process of long term data collection can incidence

reduction be determined, which is the ultimate goal of primary preventive counseling.

The evaluation methods to be employed in this effort are standard. Whenever possible, it is desirable to use experimental designs with randomization and control or contrast groups. Failing that, which is often the case in the "real world" of primary prevention, then quasi-experimental research designs (Campbell & Stanley, 1963) become very suitable. Gaining increasing favor these days is use of multivariate designs that enable researchers to examine multiple dependent measures simultaneously, and the use of qualitative, n = 1 designs, that provide for the intensive study of a few individuals over time.

Research issues in primary preventive counseling are generally the same as those found in many other field research (Price, 1983) and program evaluation areas (Cowen, 1984). However, in what is perhaps an understatement, the effort is "fraught with difficulties" (Wilson & Yager, 1981, p. 594).

Bloom (1977) and Baker, Swisher, Nadenichek, and Popowicz (1984) have identified many of the difficulties facing primary prevention researchers including: Are both goals and methods stated clearly? What is the relationship between program goals and methods? Is psychological growth in the target group assessed in relation to a no-program control group? Are the dependent measures being used appropriate to the task and to the population? Are these measures sensitive to the goals of the change program? Are a number of data sources being used? How do their results interrelate? Are long-range results examined? How important are the changes that have been found? And how does one measure the "non-occurrence" of problems, which is a main goal of primary preventive counseling and other primary prevention efforts?

Only recently have effective studies of primary prevention programs been appearing in the professional literature. Illustrative sources include the following. Baker et al. (1984) found encouraging results when they used meta-analysis to investigate 40 primary prevention studies. Shaw and Goodyear (1984) guest-edited two special journal issues on primary prevention that contain a number of credible programs and studies. In another special journal issue that Cowen (1982) guest-edited, he organized a set of primary prevention programs that were judged to effectively meet the necessary program evaluation standards set out for them. Finally, as was mentioned in the introduction to Section III, 14 stellar

programs have been identified by an APA study group. Technology transfer workshops are being planned for locations across the country and a practical case book is being prepaid (Bales, 1987) so that practitioners can become informed more easily.

In the end, the real issue may not be planning and evaluation at all, as considerable recent progress in this area has been made. Rather, the real issue may be *valuation* (Price, 1978; Wilson & Yager, 1981). The counseling heritage of helping leads to a natural proclivity to serve. This is as it should be, but sometimes in the drive to be helpful, the importance of planning and evaluation gets placed at too low a priority. In today's world of accountability, showing evidence of effectiveness has become a survival skill (Hershenson & Power, 1987).

Finally, we must remember, especially in primary preventive counseling, that planning and evaluation are an integral part of the intervention process, thus requiring both our valuing and our best energies.

SUMMARY

In this chapter has been examined briefly the important planning and evaluation steps that accompany and support every intervention. The following planning sub-steps were considered: (1) identify a generative base, (2) assess needs and targets, (3) set goals, (4) select strategy, and (5) prepare for implementation. Program evaluation was then examined, with attention given to its two main forms: (1) formative evaluation, or the monitoring and regular feed-back of process results and events; and (2) summative evaluation, which is concerned with program outcomes of both a mid-range and a long-term nature. The emphases was that planning and evaluation are integral and critical steps to primary preventive counseling projects.

ISSUES FOR REFLECTION AND DISCUSSION

1. The importance of planning and evaluation for primary preventive counseling has been stressed. Try to put this message into your own words. Having done so, do you agree?

2. What is the role of feedback in the Planning-Intervention-Evaluation model? If you were a program planner, how would you want to use feedback?

3. How can a representative task force be useful in planning?

4. How do formative and summative program evaluation differ?

5. Explain the two main forms of summative evaluation.

6. Suppose you were a primary preventive counselor employed by a community mental health center. Your charge is to begin a program to reduce alcohol abuse among teens in your catchment area. Use the planning and evaluation model presented in this chapter to design how you would fulfill this responsibility.

HIGHLY RECOMMENDED SUPPLEMENTARY READINGS

Cowen, E. (Ed.). (1982). Research in Primary Prevention in Mental Health. *American Journal of Community Psychology, 10,* 239-367. Whole Number.

This source presents primary prevention in mental health programs that have been carefully selected for their adherence to rigorous criteria of program evaluation.

Cowen, E. (1984). A general structural model for primary prevention program development in mental health. In M. Shaw & R. Goodyear (Eds.), Primary Prevention in the Schools. *Personnel and Guidance Journal, 62,* 485-490.

This article presents a five-step program developmental model for conducting primary prevention in mental health. Its attention to the concept of "generative base" is most useful.

Craig, D. (1978). *HIP pocket guide to planning & evaluation.* Austin, TX: Learning Concepts.

This manual and workbook presents a coherent and highly useful model for planning and evaluating that especially focuses on the planning process.

National Institute on Alcohol Abuse and Alcoholism. (1978). *Planning a prevention program.* Washington, D.C.: USDHEW Pub. No. (ADM) 78-647.

This handbook, specifically intended for the youth worker in an alcohol service agency, contains much practical guidance for any primary prevention worker.

Shaw, M., & Goodyear, R. (Guest Editors). (1984). Primary Prevention In Schools; Primary Prevention on Campus and in the Community (Two Special Issues). *Personnel and Guidance Journal, 62,* 443-495; 507-562.

> These two special issues present carefully selected primary prevention articles that address the settings of schools. While not all contain evaluation results, most do. All give good attention to the planning process.

Wilson, F., & Yager, G. (1981). A process model for prevention program research. In R. Remer (Guest Ed.), The Counselor and Research: Part I. *Personnel and Guidance Journal, 59,* 590-595.

> This article presents a tightly-constructed recursive model for conducting prevention research that appropriately emphasizes the roles of planning and evaluation.

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SECTION IV

ACADEMIC PREPARATION

INTRODUCTION TO SECTION IV

Education and training in primary preventive counseling may be the ultimate issue confronting interested parties. For the individual student, it takes the form of, "How can I get the training I need for this when my academic program is so tightly prescribed and when I need so many other courses?" Academic program faculty, for their past, experience the issue as, "We hold many things dear: Therapy, career development, research, prevention. Given the demands of accreditation and licensing bodies, how can we accord more resources to training in primary prevention?" On top of these concerns, no one (including authorities in the field) can say for sure what full education and training in primary prevention, or in primary preventive counseling, should look like.

Recognizing all that, Chapter 10 contains a proposed concept about appropriate education and training in primary preventive counseling. This material may spark some controversy and it might provide some guidance. The intent is to be helpful to both students and faculty as academic preparation is actively considered.

CHAPTER 10

EDUCATION AND TRAINING

If a hale and hearty primary preventive counseling is to exist, it will emerge from the professional academic preparation programs of tomorrow. In reviewing the subject of prevention training in depth, Zolik (1983) cast the following long shadow:

> ...as the knowledge required for prevention is not always the same as that required for treatment, the need for modification in training programs is a paramount concern if training is to be improved...New training formats must be explored; interdisciplinary dimensions must be introduced; current guidelines for accreditation must be challenged. Otherwise training obtained at the predoctoral level will by necessity have to be completed at the post-doctoral level into the indefinite future. (p. 287)

Zolik's words will be drawn upon to generally shape the directions of this final chapter. Therefore, education and training (E & T) in primary preventive counseling will be examined in terms of (1) required basic knowledge and skills, (2) interdisciplinary contributions, (3) training formats needed, and (4) external and internal forces.

This discussion of education and training will be pitched at the doctoral level, although elements of it are very appropriate for the master's level, as well. Yet, the doctoral level is where the best opportunity would seem to exist for building on core counseling knowledge and skills that have been gained through earlier graduate study.

BASIC KNOWLEDGE AND SKILLS

Because primary preventive counseling is a newly forming approach, no one knows what constitutes the "right stuff" for education and training. Only rough approximations can be offered, such as what follows.

The basic knowledge and skills needed for primary preventive counseling are both similar to and different from those necessary for conducting remedial counseling. The similarities are traceable to the fact that primary preventive counseling, after all, is a type of counseling. Therefore, it should rely upon a core of basic knowledge and skills that is common to all counseling types. Yet, as Cowen (1984) has observed about mental health professional training, the differences are profound. The "normal stuff" of remedial counseling is insufficient for work in primary preventive counseling. Let us take a look at the basic knowledge and skills needed for primary preventive counseling.

The Counseling Core

As Price (1983, p. 295) has emphasized with reference to preventive psychology, it "...would be a serious strategic and intellectual error" for departments of psychology to create separate programs. Primary prevention does not stand apart in isolation from existing psychology specialties and, in fact, it is being embraced by many (e.g., community, school, counseling, developmental) as an important direction for training, research, and practice.

I believe the same situation holds for professional counseling and counseling psychology. For instance, in the Counseling program at the University of Cincinnati, the master's level specialties of school counseling, mental health counseling, rehabilitation counseling, and student development counseling each carries a primary preventive torch. Carving out another independent specialty in primary preventive counseling would make as little sense as making one, let us say, for remedial counseling.

Nor would it be sensible to locate a sub-specialty of primary preventive counseling within just one of the existing specialty areas, such as mental health counseling. What about students in the rehabilitation,

school, and student development counseling specialties who also may be interested in primary preventive counseling?

No, a more feasible approach would be for faculty to include in their core required courses focused attention to primary prevention issues and for students who are especially interested in primary prevention to select courses accordingly, whenever a choice is possible. This approach recognizes that primary preventive counseling is but one form of counseling while also supporting the reality of its uniqueness. Examples will be provided later in this Chapter.

This position further underscores the importance of tying primary preventive counseling into a core of counseling courses. This core of courses should address the knowledge and skills needed in counseling theory, practice, research, and supervision. In a general sense, these core courses should cover: (1) counseling theory and technique, (2) vocational theory and career counseling, (3) critical issues and ethics, (4) measurement and assessment, and (5) research.

Depending on the inclination of the program faculty, the core courses (as well as additional courses) might also meet the standards or guidelines of certain external bodies. Among those of relevance to professional counseling are the guidelines of the American Psychological Association for Programs in Counseling, the Council for Accreditation of Counseling and Related Educational Programs (CACREP), regulations for state Counselor Licensure (if available in that state), and regulations for state Psychologist Licensure.

Note that the more closely a training program adheres to meeting the standards and guidelines of external bodies, the less flexibility exists for students in the program to design their own program. An uncomfortable tension results in such situations that must be continually monitored by the faculty.

And yet, the core courses can be constructed so that they can fit with external considerations and be at least partially sensitive to primary prevention needs. For example, in our doctoral program, students must take courses or meet prerequisites in consultation, professional orientation to counseling, program development and evaluation, and career development, among others, all of which are naturally suited to primary preventive counseling.

In addition, other required courses, such as advanced practicum and internship, can be tailored specifically to address primary preventive counseling needs and settings. Thus, students can meet their advanced practicum or internship requirements through working under supervision in a university alcohol education center or in a consultation and education unit of a community mental health center, engaging in programs that are primary preventive in scope. (See Lewis & Lewis, 1981; Libassi, 1984; and Zolik, 1983, for some intriguing illustrations). The faculty would have to locate field training sites that provide adequate supervised experience in both person-centered and system-centered approaches to primary preventive counseling.

Doctoral programs in counseling that seek to prepare their students for Licensure as a Psychologist and/or as a Professional Counselor will need to require a set of courses that meet specific sections of the relevant state licensure regulations. Again, in our case, we require a support area called, "Foundations of Counseling," which intends to meet these licensing criteria and, also, to provide the student with a solid understanding of the different social and psychological influences or determinants of human behavior.

Therefore, our students take certain courses from prescribed areas of human behavior, such as (1) biological foundations (e.g., physiological psychology); (2) cognitive/affective foundations (e.g., learning); (3) social foundations (e.g., organizations and systems); (4) individual differences foundations (e.g., human development); and (5) industrial/organizational foundations (e.g., organizational consultation). Once again, it is possible, within limits, for those students who are interested in primary preventive counseling to select courses that are most pertinent to it, such as an organizational consultation sequence.

This section on core courses will be concluded with these words of Cowen (1984):

> Hence, some of the standard stuff of clinical training is relevant in preparing primary prevention specialists in mental health. But large time-consuming portions of such training, as in the detailed practice of psychodiagnosis, psychotherapy, and classically defined internships, are less essential to the new role. (p. 257)

Primary Prevention Support Area

A student with primary preventive counseling interests should be able to dedicate several credit hours of courses strictly to primary prevention. We use a rough guideline of 24 credit hours (eight courses) in our Counseling program to constitute a "support area" for purposes such as this one. These courses, plus those with a primary prevention focus that reside in the core curriculum (especially the advanced practicum and internship), provide a minimum level of specialized training in primary preventive counseling.

Certainly, eight courses cannot begin to cover all that is needed. But, they offer a step in the right direction. What sorts of knowledge and skills should be represented in the eight courses selected?

According to Lewis and Lewis (1981) a primary preventive counselor should be able to exercise three basic sets of skills: (1) educational, (2) program development, and (3) change agent. Their thinking is that *educational* skills are necessary for the counselor to enhance the competencies of a target group, through such means as courses, seminars, workshops, and media forms that are based on carefully-designed instructional formats. *Change agent* skills are required for getting involved with human systems and empowering them to positively change. And *program development* skills are necessary for the effective implementation of either educational or change agent efforts; the counseling practitioner must be able to convert an idea into concrete, attainable goals and methods.

Cowen (1984), in examining training for primary prevention in mental health, identified much the same set of knowledge and skills. Moreover, he indicated content areas that can most readily address their development, and from which a primary prevention support area could be constructed. This information is presented in Chart 10.1, followed by a brief discussion in text of each area.

Education. Cowen saw education, defined broadly, as critical for promoting strength and competencies in individuals, with mass media approaches becoming more important. The kind of knowledge needed can be obtained from developmental psychology (for a generative base), educational psychology and education (for writing sound curricula and how to present their contents), and perhaps the social psychology of mass communication (for effective development and use of media).

CONTENT	DISCIPLINE
Education	Developmental Psychology Educational Psychology and Education Social Psychology
Structural Change	Social Science cluster
Support Groups	Social Psychology Social Ecology Social Work Sociology
Program Development & Evaluation	Psychology (Dev, Soc, & Educ) Social Ecology Social Work Epidemiology
Community Mental Health	Community Psychology Counseling Planning Management
Training	Primary Preventive Counseling Practica and Internship

Chart 10.1. Interdisciplinary content areas for a primary prevention support area.

Knowledge of Structures and of Their Change. This is very similar to the change agent skill area suggested by Lewis and Lewis. In order to reduce the sources of stress in peoples' lives, an attempt at some form of system change is often necessary. This kind of knowledge can best be obtained from the social-psychological sciences: sociology, social ecology, social and environmental psychology, architectural planning, political science, and economics.

Support Groups and Networks. Because stress seems more highly deleterious to those who are isolated and lacking interpersonal support, a growing body of research suggests that support groups and networks can be helpful as stress-buffers. The knowledge base for this kind of approach can be found in social psychology, sociology, social ecology, and, I would add, social work.

Program Development and Evaluation. Primary preventive efforts depend on the development, implementation, and evaluation of intentional programs that are delivered before-the-fact to groups of at-risk-people. The skills of program development and evaluation are essential to any primary prevention activity, as has been observed in Chapter 9. Cowen saw this knowledge base deriving from the areas of developmental, social, and educational psychology; social ecology; and epidemiology. Social work is another good source for this material.

Community Mental Health. Primary prevention programs occur in organized settings, such as work, family, and neighborhoods. The community mental health skills of entree, negotiation, consultation, and crisis intervention are essential to this end. Although Cowen did not say so, these skills can be found in community psychology, social work, counseling, planning, management, and other programs.

Training Centers. Cowen strongly suggested that a limited number of field training centers be established to model and catalyze cutting-edge work in primary prevention program development, research, and the training of future leaders in this area. Let me add that not enough can be said for academic program faculty locating, or helping to create, community field training sites that are appropriate for students in primary preventive counseling. For in such sites is where students will best be able to begin testing and integrating primary preventive counseling concepts and methods.

INTERDISCIPLINARY CONTRIBUTIONS

No doubt the content and methods for conducting primary preventive counseling, by definition, must be drawn from a variety of disciplines. In fact, when considering intervening at the systems level, you may have noticed that sociology and the social sciences rather than psychology and the behavioral sciences, are main sources.

Does one have to be a virtual Renaissance person in order to engage in primary preventive counseling? The answer is no, and three implications of that question are especially important.

First, primary preventive counseling must be recognized as a complex endeavor that taps a wide range of academic and practical content. Any one counseling program cannot be expected to supply all the necessary instructional resources. Thus, students who are interested in primary preventive counseling must look to other disciplines for designing their plan of study. While education and psychology will be strong contributors, so could sociology, social work, planning, and others.

Second, the counseling or counseling psychology program (the "home" program) should facilitate and help integrate this interdisciplinary process for students, while attempting to include a primary preventive focus wherever possible and appropriate in the existing program. For instance, to be sure that such a focus is available within courses at the University of Cincinnati, a new elective course in "preventive counseling" has been added.

Third, any one student cannot possibly learn all that is necessary! Rather, as Cowen rightfully pointed out, we need to assist students to learn where the relevant knowledge can be found and in how to gain access to it effectively. Resourceful graduates—those who know some of the "right stuff" and, importantly, how to find the rest they need—stand by far the best chance of functioning successfully as primary preventive counselors.

TRAINING FORMAT CHANGES

Even though most existing doctoral programs in professional counseling and counseling psychology are very tightly

organized—especially if they are attempting to meet external guidelines, such as Licensing—students can obtain at least a minimum level of education and training in primary preventive counseling. Hopefully, the material previously presented in this chapter will assist in that effort.

In-depth education and training, however, is not possible, given current realities. You can remember from Chapter 2 of this book that a number of economic and political factors, such as a press to private practice, combine at present to keep the positive rhetoric about primary prevention from becoming a reality in training programs.

And yet the national social climate may be undergoing a kind of change that is much more in accord with this new type of counseling. To illustrate we turn to the popular press (Moffitt, 1986) and an excerpt about a change the author saw occurring in our society from emphasizing individual achievement and advancement to an embracing of the common good. This quotation bears directly on the issue of "rhetoric versus reality" for primary preventive counseling:

> At first I thought I was making all this up, seeing isolated instances as a trend that really only existed in my imagination. But a few months ago, I was invited to attend a planning retreat for the faculty, staff, and trustees of the largest professional school of psychology in the U.S. They were attempting to propose an agenda to see their school to the year 2000. I listened with amazement as, over the few days it took, there developed a consensus: Almost unanimously they wished to switch their primary focus away from private-practice psychology—where the big money is—to a social advocacy a part of their stated purpose. (p. 48)

To the extent that this observer's vision is correct it is good news, indeed, for primary preventive counseling. The theme of a "social" practice, compared with that of a "private" practice, underlines the importance of working through systems to empower people to help themselves, thus enabling them to avoid the patient role.

Thoroughly training professionals to do this kind of primary prevention work, however, would require adjustments in training programs, as many have observed. *In addition to* the critical aspects of training in primary preventive counseling that have been already mentioned, what new training formats might be needed? Chart 10.2 presents my best guess at answering this question.

Chart 10.1 Material

plus

Ecological Perspective

Primary Prevention Perspective

Expanded Counseling Perspective

Training Program Flexibility

Increasing Program Resources

Marketing Knowledge

"Non-traditional" Research

Chart 10.2. Toward a more thorough training in primary preventive counseling.

Ecological Perspective

The dominant conceptualization of help-giving would need to change from its historic intrapsychic foundation to a person-environment one. This change is in mind-set and it is a profound one. It has direct implications for understanding how both growth and problems develop and for how to intervene. One of the clearest products of an ecological perspective is the whole range of environmental interventions that becomes possible in counseling. I have dubbed this kind of emphasis "counseling ecology" (Conyne, 1985), an orientation that Hershenson and Power (1987) have identified as the counseling model most closely linked philosophically to mental health counseling. If, indeed, these authors prove to be accurate, primary preventive counseling can benefit greatly.

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Primary Prevention Perspective

While this is perhaps so obvious it need not even be mentioned, it is so significant that I must do so. Here, the historic individual-reparative understanding of help-giving is relaxed to allow for help-giving that is before-the-fact, aimed at presently healthy groups of people who are at risk in some real way. Again, as with the ecological perspective, this is a watershed kind of mind-set change having a host of practical applications that you have read about in this book.

Expanded Counseling Perspective

When summed, the first two items mentioned require a broad conception of counseling, one that comfortably allows for work with systems and the indirect provision of services, for example. Faculty need to allow for such a perspective in order to support genuinely the education and training of primary preventive counselors.

Training Program Flexibility

As a commitment to primary preventive counseling increases, possibly greater flexibility can be injected into training programs. For example, all students may not need to or desire to meet stringent licensing requirements. Or perhaps the core courses in a counseling curriculum could be modified. These kinds of changes could allow for providing more substantial training in primary prevention.

Increasing Program Resources

This point is a corollary to the provision of greater program flexibility. Survey results have shown that the commitment of faculty resources to primary prevention is relatively low compared with that to remediation (e.g., see Zolik, 1983). Counselor training programs would need to increase and strengthen the faculty involvement with primary prevention. Attention would need to be given, too, to all other facets of the counseling program to assure that primary preventive counseling would be adequately supported.

Marketing Knowledge

Far too many primary prevention programs "die on the vine" due to a failure to attract and hold target people. When the issue is clearly

one of attraction, program designers need to examine ways in which they made the program known to potential participants. These are marketing questions. Counseling and counseling psychology training programs typically do not address issues of marketing, for a variety of reasons. The primary preventive counselor, however, must be as able to market programs as he/she is able to design, conduct, and evaluate them. Turning to the Marketing Department for courses in social marketing is recommended.

"Non-traditional" Research

Research and evaluation methods traditionally taught in our training programs emphasize experimental design and counseling process studies. Of course, other reputable research methods are available, which may be even better suited for certain primary preventive counseling projects. These methods include epidemiology, naturalistic studies (e.g., ethnography), qualitative modes (e.g., case study), and multifactoral designs.

Note that three of the seven changes in training formats I have discussed involve alterations in *perceptions:* For program faculty and students

1. to accept as valid an ecological orientation to help-giving,
2. to subscribe to the concept of primary prevention as a legitimate avenue for providing help, and
3. to allow for an understanding of counseling that is set within an inclusive framework.

My opinion is that once these three perceptions are endorsed, then resources and curricular matters can become more effectively and efficiently handled.

EXTERNAL AND INTERNAL FORCES TO BE CHALLENGED

Students can now be minimally trained in primary preventive counseling by attending to considerations presented in this chapter. To

do so a strong interdisciplinary orientation, committed faculty, interested students, and considerable creativity are required.

Realistically, however, one must recognize that most graduate counseling and counseling psychology programs are inflexible, dominated by standards and guidelines required by various accreditation, licensing, and credentialing bodies. Moreover, the main thrust of these bodies is reinforcing of counseling for remediation, even though signs are all around us that primary prevention, wellness, health promotion, and a "social" practice represent a growing trend. What results for many students and faculty, of course, is an uncomfortable tension and a sense of powerlessness about how to resolve these conflicting realities.

While faculty can flail away at the behemoths of external regulation in the field, no quick relaxation of guidelines can be expected. That's not to suggest that efforts to produce greater flexibility about what constitutes "proper" counseling and counseling psychology training should not continue with gusto.

However, to bring about change, the faculty in each academic program must squarely face the question of where primary prevention ought to be in their curriculum and how many resources, if any, should be devoted to it. We need not let the "tail" of the external bodies wag the "dog" of academic programs. The time is now, as many observers of the scene have said, for us to decide the actual—not the rhetorical—status of primary prevention in professional counseling, and counseling psychology, and then to take the necessary action internally and externally to make that happen.

A major purpose in writing this book was to contribute to discussions of these contributions by faculty and students. This attention is a necessary precursor to professions and professionals taking an active role in primary preventive counseling.

SUMMARY

This final chapter of the book addressed the thorny issue of education and training in primary preventive counseling. What has been provided is a possible means to provide minimal training in this new type of counseling by creatively selecting courses in required categories and by

building an interdisciplinary support area in primary preventive counseling. Courses in the support area might address education, structural change, support groups and networks, community mental health, and practica/internships. These courses would be selected from a wide range of departments.

In-depth training is yet another matter, requiring program faculty to come to hard decisions about the real status which primary prevention will occupy in their programs. Further evidence of commitment to primary preventive counseling would be found in the endorsement by program faculty of perspectives in ecology, primary prevention itself, and an expanded concept of counseling. As well, these faculty would provide for increased program flexibility and resources, while recognizing the importance of marketing and "non-traditional" research in primary preventive counseling.

ISSUES FOR REFLECTION AND DISCUSSION

1. Primary preventive counseling is similar to, but also different from, remedial counseling. What basic knowledge and skills are compatible to both approaches and what is unique to primary preventive counseling?

2. Is it possible in your academic program to build a support area in primary prevention? If so, what would you want to include in it?

3. Primary preventive counseling is presented as relying on an interdisciplinary base. Give some examples of how this is so.

4. Describe an advanced practicum or an internship experience that you think would fit well with primary preventive counseling.

5. How accurate is the perception about the dawning of a "social" practice? Illustrate your position with some examples.

6. What steps can academic program faculty and students take to support the growth of primary preventive counseling?

7. Now, after reading this book, how interested are you in primary preventive counseling? Discuss.

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HIGHLY RECOMMENDED SUPPLEMENTARY READINGS

Cowen, E. (1984). Training for primary prevention in mental health. *American Journal of Community Psychology, 12,* 253-259.

> This article presents a definition of primary prevention in mental health, and then identifies the methodologies, content areas, and specific training needs that must be addressed.

Lewis, J., & Lewis, M. (1981). Educating counselors for primary prevention. *Counselor Education and Supervision, 29,* 172-181.

> This article identifies the education needed by counselors who wish to engage in primary prevention. Educational program development, and change agent skill clusters are highlighted.

Zolik, E. (1983). Training for preventive psychology in community and academic settings. In R. Felner, L. Jason, J. Moritsugu, & S. Farber (Eds.), *Preventive psychology: Theory, research, and practice,* 273-289. New York: Pergamon.

> This chapter comprehensively explores training needs and directions in both field and academic settings and at various levels of education, undergraduate through postdoctoral.

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He resides in Cincinnati, Ohio with his wife and colleague, Lynn Rapin, and their two young children, Suzanne, age three, and Zachary, one year.

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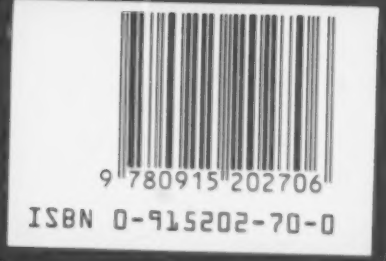

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